SUBCOMMITTEE NO. 3 Agenda
Health, Human Services, Labor & Veteran's Affairs

Chair, Senator Denise Ducheny

Senator Wesley Chesbro
Senator Dave Cox

May 8th, 2006

1:30 PM
(Please note time change)

Room 2040
(Please note room change)

(Diane Van Maren)

Item	Department
4300	Department of Developmental Services—*Selected Issues*
4260	Department of Health Services—*Selected Issues*
4440	Department of Mental Health—*Selected Issues*
4280	Managed Risk Medical Insurance Board—*Selected Issues*

PLEASE NOTE:

Only those items contained in this agenda will be discussed at this hearing. *Please* see the Senate File for dates and times of subsequent hearings.

Issues will be discussed in the order as noted in the Agenda unless otherwise directed by the Chair. Thank you.

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A. ITEMS FOR DISCUSSION-- Department of Developmental Services

1. Extension of Liquidation for Bay Area Housing Plan—Agnews Closure

Issue. The Subcommittee **is in receipt of a Finance Letter that requests an extension of the liquidation period of the $11.1 million (General Fund) designated to facilitate the development of community-based living options for the current residents of Agnews Developmental Center.** These funds were originally appropriated in the Budget Act of 2004 and then re-appropriated in the Budget Act of 2005.

The DDS states that an extension is necessary to accommodate the projected time horizon required to complete the acquisition of permanent housing. **As noted in the language below, this request allows the appropriation to remain open until June 30, 2010**.

Specifically, the DDS is requesting the following reappropriation language:

> 4300-491-Reappropriation, DDS. Notwithstanding any other provision of law, the period to liquidate encumbrances of the following citations are extended to June 30, 2010

The DDS notes that the financing arrangement has been a complex and time consuming negotiation, requiring a tri-party agreement between the Bank of America, the CA Housing Finance Agency (CalHFA) and Hallmark (the master developer). Acquisition and construction financing will be provided to Hallmark by the Bank of America with permanent financing provided by CalHFA via bond sales. This financing arrangement is currently in the final stages of negotiations.

In addition, DDS has prepared a contract amendment that has been agreed to by the three Bay Area Regional Centers (i.e., East Bay RC, Golden Gate RC, and San Andreas RC) to transfer funds, provide accountability, and administer the approved Expenditure Plan funding and the Bay Area Housing Plan. The DDS states that the success of the Agnews closure plan relies on the RCs ability to secure housing for its residents.

According to the DDS proposal, between the current year and 2009-10, a portion of the $11.1 million will be transferred to CalHFA upon establishing permanent loan financing. These funds, up to $6 million, will be held in an interest bearing account by CalHFA until such time as the aggregate outstanding principal value of all of the loans does not exceed the value of the properties. In addition, there may be a need to expend these funds for the pre-development costs of securing property, such as escrow deposits, architectural fees, abatement of asbestos and other hazardous materials.

Subcommittee Staff Recommendation. In the Subcommittee hearing of April 3rd, the DDS eluded to the need to extend the appropriation timeframe. The project continues to be consistent with AB 2100, Statutes of 2004, the enabling legislation and the Administration's plan to close Agnews DC. It is just taking more time to develop the framework for proceeding than originally anticipated.

In order to ensure the oversight of the Legislature, in addition to the Administration's reappropriation language, it is recommended to adopt the following Budget Bill Language for the reappropriation item.

> "The DDS shall provide the fiscal and policy committees of the Legislature with a monthly update on the development of the housing and the expenditure of the $11.1 million. At a minimum, this shall include the following components: (1) all the properties acquired during the month, (2) the cost of each property, (3) the address of each property, (4) the square footage of any residential structures on the property, (5) the size of any lot that is purchased with the intent to build on it, (6) estimated construction and/or renovation costs for each property before construction and/or renovation begins. In addition, funds expended for the pre-development costs of securing property, such as escrow deposits, architectural fees, abatement of asbestos and other hazardous materials, shall be reported."

It should be noted that the DDS will be providing the Joint Legislative Budget Committee (JLBC) with this information, as applicable, beginning in May 2006 as had been requested in a letter last Fall. The Legislative Analyst's Office concurs with the need for this proposed Budget Bill Language in order to maintain oversight by the Legislature.

Questions. The Subcommittee has requested the DDS

1. **DDS,** Please provide a brief summary of the request for the reappropriation language, including a status update on expenditure of the funds and why an extension to June 30, 2010 is necessary.

2. Feasibility Study for Medicare Part D Drug Program—Developmental Centers

Issue. The DDS is requesting **an increase of $694,000 (General Fund) for the implementation of, and compliance with, requirements of the Medicare Part D Drug Program.** Of this total amount, $380,000 is one-time only to fund a contract for services to perform an assessment of the DDS' Cost Recovery System. The remaining $314,000 would be ongoing and would be used to offset the loss of Medi-Cal reimbursement that will result from the implementation of the Medicare Part D program.

***First*, the $380,000 in one-time funds will be used to hire a contractor to perform various activities associated with the DDS' Cost Recovery System, including development of a Feasibility Study Report that makes recommendations for improved system operations that are consistent with federal mandates for billing.** The DDS utilizes the Cost Recovery System for the identification, billing and recovery of costs of operating the Developmental Centers (DCs). It is an old system that has been in operation for over fifteen years.

The DDS states that changes to its existing Cost Recovery System are needed, and are greater than originally anticipated, to accommodate the Part D Drug Program. Specifically, the data required by the Medicare Part D Prescription Drug Plans (PDP) is more detailed and of greater quantity than other types of billings produced by the DDS' Cost Recovery System. For example, the PDPs are requiring a "point-of-service" real-time system for billing and other operations such as eligibility verification, appeals, claims adjudication, and routine communications.

The contractor to be hired by DDS is to convert the Cost Recovery System output into standardized billing formats as well as perform many other functions. DDS is concerned that even with these proposed enhancements to the system, there are likely to be problems in its operations due to the various complexities at hand, including needed changes for the federal Health Information Portability and Accountability Act (HIPAA), billing format changes mandated by the federal CMS and the need to interface with the State Hospitals operated by the DMH. Therefore, funding for a full assessment of the Cost Recovery System is requested.

***Second*, DDS is seeking to backfill $314,000 in federal reimbursements with General Fund support.** Currently DDS captures Medi-Cal reimbursement for DC-related administration activities at the DDS Headquarters based on a rate that is determined by the Medi-Cal eligible costs at the DCs. This Medi-Cal reimbursement rate will be reduced by the drug costs for dual eligibles that were previously billable to Medi-Cal but will now be paid by Medicare or the General Fund.

This reduced Medi-Cal billable rate when applied to the DDS Headquarters will result in a $314,000 reduction in Medi-Cal reimbursements that will need to be backfilled with General Fund. The DDS states that they cannot afford to absorb this reduction without sacrificing needed program oversight.

Background—Developmental Centers and the Medicare Part D Program. DDS serves over 210,000 individuals with developmental disabilities. Of these individuals about 40,000 are affected by the Medicare Part D Program and about 2,200 of these individuals live at the Developmental Centers (DCs). DDS provides direct services to the individuals at the DCs including prescription drugs and pharmacy services. **DDS presently uses an "all-inclusive" bundled rate under its Cost Recovery System to bill the Medi-Cal Program and to account for expenditures.**

As part of the implementation of the Part D Program at the DCs, the DDS is required to identify the prescription drug and dispensing costs for each dual-eligible consumer and bill that consumer's approved costs to their individual Medicare Part D "Prescription Drug Plan" (PDP). **In order to accomplish this, the pharmacy costs for all consumers at the DCs affected by Part D must be segregated from the all-inclusive rates billed to Medi-Cal to avoid billing Medi-Cal for any Part D services and costs.**

Subcommittee Staff Recommendation. It is recommended to approve the request as proposed. No issues have been raised.

Questions. The Subcommittee has requested the DDS to respond to the following question.

1. **DDS,** Please provide a brief summary of the request.

3. Various Capital Projects at Porterville Developmental Center *(Issue A & B)*

Issues. The DDS **is requesting appropriation authority to fund several capital outlay projects at the Porterville Developmental Center (DC).** Porterville is the only DC that operates programs for individuals with developmental disabilities who have forensic and penal-code related offenses. There are presently about 300 clients in the secure treatment program (at capacity), and there is a waiting list of between 20 to 55 individuals. Consumers are usually court-ordered to the facility. **Each of these capital outlay projects is discussed below:**

A. Porterville 96-Bed Expansion and Recreation Complex Project. The Budget Act of 2003 provided a total appropriation of $56.5 million (lease revenue bonds) to construct a 96-bed expansion and to construct a recreation complex at Porterville DC.

The Subcommittee is in receipt of a Finance Letter requesting to: (1) revert the unencumbered bond authority from the Budget Act of 2003; **(2)** combine the two projects into a single appropriation for construction; *and* **(3)** provide an appropriation of $78.5 million (lease revenue bonds) for the construction phase.

The amount to be reverted is a total of $56.5 million (lease revenue bonds) for the two projects ($5.8 million for the recreation center and $50.8 million for the 96-bed expansion). The amount to be appropriated is $78.5 million (lease revenue bonds) for both projects. The DDS states that an increase is needed due to price increases in raw materials and the demand for labor since this project was first funded in 2003.

The DDS also merges the two projects for construction purposes because it is easier to bid both projects together for various reasons. **DDS states that the construction is to begin in September 2006 and is to be completed in May 2008.**

Subcommittee Staff Recommendation. It is recommended to approve this Finance Letter.

Questions. The Subcommittee has requested the DDS to respond to the following question.

1. **DDS**, Please provide a brief summary of the proposal.

B. New Main Kitchen & Renovate 24 Satellite Kitchens/Dining Rooms

The DDS is requesting a total of $23.7 million ($22.6 million in lease revenue bonds and $1.2 million in General Fund) to fund the following:

(1) The new Main Kitchen at Porterville, including preliminary plans, working drawings, and construction (i.e., the entire project); *and*

(2) The preliminary plans to renovate 24 satellite kitchen/dining rooms in the residence areas to bring them into code compliance.

***First,* the appropriation for the *new* Main Kitchen consists of $22.6 million (lease revenue bonds) for the entire project (29,000 square feet).** The new Main Kitchen would replace a seismically deficient kitchen with functionally deficient equipment. The deficiencies at the kitchen have led to many citations for health violations. The Department of General Services has determined that the Main Kitchen is in such disrepair that it would be more expensive to repair and seismically retrofit than to construct a new one. Every day about 2,400 meals are served at Porterville.

The Legislative Analyst's Office recommends rejecting the proposal for the new Main Kitchen and instead, recommends only $1.1 million (General Fund) to proceed with just the preliminary plan phase of the project. This is recommended in order to provide more legislative oversight.

The LAO notes that this is a complex project and that it will take several years to complete. If lease revenue bonds are used to fund the project as requested, the Legislature would have to authorize funding for preliminary plans, working drawings and construction at one time. This is because lease revenue bonds cannot be used to fund only preliminary plans (i.e., usage of bond funds requires the assurance that a project will be constructed). They believe this reduces the Legislature's oversight of the project. In addition, the LAO contends that a more detailed cost estimate is needed on this project.

Subcommittee staff recommends approval of the Administration's proposal for the new Main Kitchen. The use of lease revenue bonds is appropriate for this purpose and the Public Works Board assists in providing oversight. **It is a new construction project, versus a remodel, and therefore should be treated as a package.** The Department of General Services has noted its condition and need for timely completion, particularly with the 96-bed expansion. Dividing the project up into phases would also slow the project down and extend its timeline.

***Second,* the appropriation for renovating the 24 satellite/dining rooms is $1.2 million (General Fund) to prepare preliminary plans.** The DDS states that of the 30 satellite kitchen/dining rooms at Porterville, 24 of them need to be remodeled to bring them into health and safety code compliance. **Of these 24, nine of the satellite kitchen/dining rooms are inside the secure perimeter and 15 are outside of the secure perimeter.**

The LAO recommends to delete this funding request due to a lack of justification. The proposal did not justify why the satellite kitchens/dining rooms needed all the proposed extensive renovations.

Subcommittee staff recommends approval of the Administration's proposal for the 24 satellite kitchen/dining rooms. These kitchen/dining rooms are located in the living areas (i.e., residences) and are in significant disrepair. Using General Fund for the preliminary plans is necessary since lease revenue bonds cannot be used to fund just preliminary plans. Further, since these satellite kitchen/dining rooms are located in the residence buildings, the DDS does not want to use lease revenue bonds for this purpose (since these bonds can only be used to finance a building's construction on a one-time basis).

Questions. The Subcommittee has requested the DDS to respond to the following question.

1. **DDS**, Please provide a brief summary of the proposal.

B. Items Recommended for Vote Only—Department of Health Services *(1 through 7)*

1. Prostate Cancer Treatment Program

Issues. The **Administration proposes to appropriate $3.478 million (General Fund) to maintain a prostate cancer treatment program.** Under this proposal, a competitive contract would be awarded for prostate cancer treatment services in the amount of $3.128 million.

The remaining amount of $350,000 is to fund administrative support for the program through contract personnel (as presently done). These expenditures include funds for 2.5 contract positions, an external review committee process, and funds for an evaluation.

The number of men able to enroll in the program in the budget year will depend upon the amount of funding available for the program and on the average cost per man to receive treatment through the program. Additionally, SB 650 (Ortiz), Statutes of 2005 specifies that 87 percent of the contract will be used for direct patient care reimbursed at Medi-Cal rates. Reenrollment criteria will be established under the new contract by the DHS.

The DHS has released a Request for Application (RFA) for the new contract. The RFA respondents are required to describe how they will establish and maintain a statewide provider network based on the criteria contained in the RFA and as it pertains to the "scope of work". This network will be required to provide all necessary prostate cancer treatment services that fall within the context of covered services as defined by the DHS with the contractor.

The administration of the program will be done via contract as well. The $350,000 would provide contract staff that would manage the treatment contract, monitor costs, respond to inquiries, and evaluate program effectiveness and quality and liaison with the program contractor. The program has historically been dependent upon contract positions housed at the state, or in-kind support provided by the DHS Cancer Detection Section staff for contract oversight. Presently, there are no positions directly associated with the program at the DHS.

It should be noted that the Administration's increase of $3.478 million (General Fund) for 2006-07 is considered to be one-time only funding. They contend that the need for ongoing funding for this program after 2006-07 will be reviewed during the 2007-08 budget process, and will be dependent upon the review of a Legislative report due as of July 2006, and experience gained by the program through implementation.

Current year funding of $2.4 million (General Fund) was provided by SB 650 (Ortiz), Statutes of 2005. The DHS has provided the following statistics on the program in the current year (as of March 7, 2006).

- Enrolled for treatment in 2005-06 — 219 men
- Re-enrolled for treatment in 2005-06 — 159 men
- Disenrolled from treatment in 2005-06 — 2 men
- Pending new enrollments — 96 men

- Pending re-enrollments 40 men

Additional Background—Prostate Cancer Treatment Program. SB 650 (Ortiz), Statutes of 2005, appropriated $2.4 million (General Fund) in the current year for the Prostate Cancer Treatment Program. It also modified the program to maximize the amount of funding spent on prostate cancer patient care services, and states that contracts awarded to implement the program after July 1, 2006 must be entered into on a competitive basis. Specifically, SB 650 specifies that 87 percent of the contract shall be used for direct patient care reimbursed at Medi-Cal rates.

DHS is required to report an evaluation of the program which is due to the Legislature as of July 1, 2006.

The current-year contract is with UCLA. A new contract will be procured through a competitive process as required by the legislation.

Subcommittee Staff Recommendation. No issues have been raised by the LAO or Subcommittee staff regarding these issues. **It is recommended to approve the proposal.**

2. CA Coalition to Cure Prostate Cancer Research Fund—Tax Check-off

Issue. The Subcommittee is in receipt of a Finance Letter that requests appropriation authority of $182,000 (Prostate Cancer Research Fund) as directed by AB 658, Statutes of 2004.

Under this law, the Franchise Tax Board collects revenue from voluntary contributions through the tax check-off portion of the personal income tax forms and is to be deposited into this special fund. These funds are to be used by the CA Coalition to Cure Prostate Cancer with resources to provide grants to further prostate cancer research.

The statute specifies that the funds are to be allocated first to the Franchise Tax Board and the State Controller for reimbursement of all costs incurred in connection with their duties under this mandate. The remaining amount is then to be appropriated under the DHS for disbursement to the CA Coalition to Cure Prostate Cancer.

Subcommittee Staff Recommendation. It is recommended to approve the proposal. No issues have been raised and the proposal conforms to the legislation.

3. Support for Ongoing Workload for Medicare Part D Prescription Drug

Issue. The DHS **is requesting an increase of $264,000 ($66,000 General Fund) to support 4 new, permanent Program Technician III positions for the Third Party Liability Branch.** These positions would be used to address the ongoing workload increase resulting from the Medicare Modernization Act (MMA) provisions related to the prescription drug coverage for individuals dually eligible for Medicare and Medi-Cal.

These positions would be responsible for researching problems pertaining to Medicare Part D enrollment of Medi-Cal enrollees identified through system transaction reports or reported by federal and/or local government staff, among others. The DHS states that resolution of these problems would ensure the accuracy of the Medi-Cal Eligibility Data System (MEDS) and maintain the integrity of the Medi-Cal Program's payment system, specifically third party liability cost avoidance**. If resolution is not achieved, the state may pay for services that should otherwise be paid by the federal government through the Medicare Program.**

It should be noted that enhanced federal financial participation at the 75 percent matching level is available for these positions.

Legislative Analyst's Office—Approve as Two-Year Limited-Term. The LAO **recommends to approve the positions as two-year limited-term positions since the Part D Program is in flux and should hopefully have some of its problems resolved within this timeframe.** After the two-year period, the Legislature can reassess the need to have them ongoing.

Subcommittee Staff Recommendation—Concur with LAO. It is **recommended to adopt the LAO recommendation.** This action would conform to the Assembly.

4. Delete Budget Bill Language Due to Error in Governor's Budget--*Technical*

Issue. The **Administration incorrectly inserted Budget Bill Language into the Governor's budget which is no longer applicable.** Specifically, prior to 2005, up to $1.3 million (General Fund) had been allocated to several counties to provide planning and start-up funding for the beginning components of an integrated long-term care program. Since this time, the projects have evolved and the Administration is proceeding down a modified policy track by focusing on different models to explore.

The Budget Bill Language was copied over from previous years and is in error. In addition, the $1.3 million General Fund it references is *not* included in the Governor's proposed budget.

Subcommittee Staff Recommendation. It is **recommended to delete provision 11 in Item 4260-101-0001 which would enable the DHS to allocate $1.3 million to counties with integrated long-term care projects.** This is recommended because the Administration inadvertently placed this language into their proposal and did not provide the General Fund support to fund it. Further, the use of these funds is no longer applicable since more work needs to be done regarding implementation of an integrated long-term care program. Policy legislation may be proceeding on this issue.

5. Erectile Dysfunction Drugs Trailer Bill Language—*Reject, Send to Policy*

Issue. In November 2005, the DHS notified providers that for dates of service on or after January 1, 2006, Medi-Cal will no longer cover drugs when used to treat sexual dysfunction or erectile dysfunction. The Administration proposed trailer bill language to effectuate this policy change. Since there are no fiscal savings associated with the proposal, it was placed into policy legislation (i.e., AB 2885 (Plescia)).

Subcommittee Staff Recommendation. It is recommended to **reject** the Administration's proposed language since policy legislation is moving on this issue (i.e., AB 2885 (Plescia)).

6. Emergency Physician's Funding of $24.8 million (Propositions 99 Funds) *(See Hand Out)*

Issue. The DHS proposes to continue an appropriation of $24.8 million (Proposition 99 Funds) and trailer bill language to reimburse physicians, surgeons and hospitals for uncompensated emergency medical services through the Emergency Medical Services Fund. This is the same proposal as adopted last year (including both the trailer bill language and the dollar amount). Further, similar appropriations have been provided for the past several years. Since the revenues deposited into the various Proposition 99 Fund accounts (i.e., Unallocated, Hospital Services and Physician Services) can fluctuate, this supplemental funding is contingent upon an annual appropriation.

Subcommittee Staff Recommendation. It is recommended to approve the proposed trailer bill language and the appropriation. No issues have been raised.

7. Export Document Program—Fee Supported Special Fund

Issue. The DHS is requesting **an increase of $228,000 (Export Document Program Fund) to hire two limited-term positions—an Associate Governmental Program Analyst and a Food and Drug Program Specialist. These positions would provide resources to review export certification requests, including applications and product labeling for conformances with state and federal regulations.** The positions would be funded with revenues collected from fees.

No fee increases are proposed since there are sufficient reserves in the special fund.

In addition, the proposal would fund the development, printing and distribution of an informational brochure to be translated into several languages and made available to applicants needing assistance in a language other than English for their export certification needs.

The DHS states that the export market for California produced foods, drugs, medical devices, and cosmetics has increased significantly. Most counties require the submission

of export documents issued by the DHS before importation of California manufactured products is permitted. The increased volume has resulted in significant delays in the completion of reviews and issuance of certificates. These delays have an economic impact and have resulted in increased complaints from exporters that their businesses are suffering due to the lengthy time required for issuing certifications.

Presently the DHS has 1.5 positions at the Office Technician level and no scientific or investigative staff. **As such, the DHS is seeking approval of two positions to complete the technical review of the export applications and product labeling.**

Additional Background. The exportation of foods, drugs, and medical devices by California manufacturers is a multi-billion dollar a year business. Most importing counties require "certificates" from the exporting state certifying that the manufacturer/distributor is currently licensed and has met all regulatory requirements. As directed by statute, the DHS must issue these certificates for these particular products.

The DHS considers two primary factors in deciding whether an export document should be issued. First, the system of manufacture and quality control used to produce the products must be adequate. This is determined by the DHS during inspections of the manufacturers, distributors and wholesalers. Second, the products must be properly labeled. This is determined by a review of product labeling at the time of export document request. Foreign countries require the export certification documents before products can be imported from California (as well as other states). The certification fees are subject to annual adjustment. However the minimum amount of $25 has not been changed since 1990.

Subcommittee Staff Recommendation. It is recommended to approve the proposal. The workload is justified and no issues have been raised.

C. ITEMS FOR DISCUSSION-- Department of Health Services

1. Newborn Screening Program—Addition of Cystic Fibrosis & Biotinidase

Issue. Though California's Newborn Screening Program was expanded in trailer bill legislation in the Budget Act of 2004, the state's program does not yet screen for the uniform panel of conditions as recommended by the federal HRSA for state screening programs and as designed by the American College of Medical Genetics. **Specifically, California does *not* screen for Cystic Fibrosis *and* Biotinidase deficiency.** As of 2005, **19 states presently screen for Cystic Fibrosis in their programs.**

Several organizations are seeking an increase in the budget to proceed with the development and pilot testing processes required to expand the Newborn Screening Program to add these two additional tests.

At the request of the Subcommittee, the DHS prepared fiscal information as to what it would cost to (1) develop a newborn screen for Cystic Fibrosis, ***and*** **(2)** develop a newborn screen for Biotinidase deficiency at the same time as the development of the Cystic Fibrosis process.

The proposed expenditures as shown below reflect **development costs** for the budget year and assume that implementation would *not* occur until August 1, 2007. The total proposed expenditures for 2006-07 would be **$8.4 million Genetic Disease Testing Fund**.

- *Development of Screen for Cystic Fibrosis.* An increase of **$5.9 million** (Genetic Disease Testing Fund) would be needed as follows:
    - Reagents (6 month supply for pilot tests) $1.6 million
    - State Personnel (5 positions at nine months) $337,500
    - Contracts for Testing Services, including laboratories follow-up, diagnostic services and 6 months of testing) $910,000
    - System Changes $2.250 million
    - External Project Manager $600,000
    - End User Training $250,000

- *Adding a Screen for Biotinidase at the Same Time.* An increase of **$2.5 million** (Genetic Disease Testing Fund) would be needed as follows:
    - Reagents (6 month supply for pilot tests) $1 million
    - State Personnel (5 positions at nine months) $202,500
    - Contracts for Testing Services, including laboratories follow-up, diagnostic services and 6 months of testing) $303,500
    - System Changes $742,500
    - End User Training $300,000

All of the proposed costs would be funded with a fee increase to the Newborn Screening Program, as shown below:

- Current Newborn Screening Fee $78.00
- Increase to Fund Cystic Fibrosis **$12.00**
- Increase to Fund Biotinidase (same time) **$ 5.75**
- Proposed Total Revised Fee $95.75

As noted above, for both the Cystic Fibrosis and Biotinidase to be added to the program (at the same time), a total fee increase of about $17.75 would need to occur, to bring the total revised fee amount to $95.75. The DHS currently has the authority to increase fees as necessary to operate the program. However, statutory change would be needed to add these two conditions to the screening panel.

It should be noted that for the development to occur to add Cystic Fibrosis and Biotinidase, the fee increase would need to occur as of July 1, 2006. However, access to the Newborn Screening test that includes these two screens will not be available until August 1, 2007. This is the same process that was used to implement the Newborn Screening Program expansion of 2005. **The development costs need to be funded prior to the screen actually being offered.**

An early diagnosis through newborn screening slows the progress of the disease and allows a child to receive appropriate medical treatment before some irreversible disease processes have begun. The federal CDC has documented that early detection for Cystic Fibrosis results in better nutritional status, improved growth and mental functioning and longer survival.

In California, more than 1 million individuals are symptom less carriers of the defective Cystic Fibrosis gene (an individual must inherit two defective genes to have Cystic Fibrosis). Each time two carriers conceive there is a 25 percent change that their child will have Cystic Fibrosis. **Based on an expected 560,000 births, a screening program would detect about 89 cases of the disease that would not otherwise be found at birth.**

The DHS has conducted a cost-benefit analysis regarding Cystic Fibrosis detection and have found that an annual health care cost avoidance of $9.1 million. This is based upon the 89 cases annually and uses a recently published benefit cost ratio for screening for Cystic Fibrosis of 2.6 (Washington State program ratio).

Background—Cystic Fibrosis. Cystic Fibrosis is one of the most common of the serious inherited childhood disorders, affecting about 3,000 children and adults in California. A defective gene causes the body to produce abnormally thick, sticky mucus that clogs the lungs and leads to life-threatening lung infections. These secretions obstruct the pancreas preventing digestive enzymes from reaching the intestines to help bread down and absorb food, often leading to impaired growth and development.

Background—Biotinidase Deficiency. Biotinidase deficiency is cause by the lack of an enzyme call Biotinidase. The deficiency of the enzyme affects normal biotin (one of the B vitamins) recycling. This results in a biotin deficiency. This deficiency occurs in about 1 in

60,000 births. Without treatment, this disorder can lead to seizures, developmental delay, eczema and hearing loss. Metabolic acidosis can result in coma and death.

The gene defect for Biotinidase deficiency is unknowingly passed down from generation to generation. This faulty gene only emerges when two carriers have children together and pass it on to their offspring. Problems can be **prevented** with biotin treatment (provided orally).

Background—Newborn Screening Program. The Newborn Screening Program was expanded in the Budget Act of 2005, and accompanying trailer bill language to include screening of additional metabolic disorders using Tandem Mass Spectrometry, as well as congenital adrenal hyperplasia. **The DHS was able to implement the program as of August 1, 2006 through the use of certain exemptions, primarily from state contract requirements, that were provided through the enabling legislation.**

Subcommittee Staff Recommendation. Though expanded in 2005, California's Newborn Screening Program still does not meet the federal HRSA uniform panel of conditions to be conducted under state screening programs, as designed by the American College of Medical Genetics. The addition of these two conditions would do this. Further, it would be cost-beneficial for the state to add these conditions to the screening process.

SB 1748 (Figueroa), as amended, proposes to include Cystic Fibrosis into the program. The legislation is presently on suspense in Senate Appropriations Committee. However, even if the legislation becomes law, implementation could conceivably take up to two years since resources would not be obtainable until much later in the process. As such, the time needed for development would be lost. Since the Newborn Screening Program is an existing program (not a new concept), consideration of its expansion through the budget process makes sense (as was done in 2005).

It is recommended to (1) adopt placeholder trailer bill legislation to be worked out with the Administration, from a technical assistance basis, to include these two conditions in the screening panel and to provide necessary exemptions, and **(2)** appropriate $8.4 million (Genetic Disease Testing Fund) for the Newborn Screening Program. This recommendation assumes that the DHS proceeds with their existing authority to increase the fees, as outlined, to accommodate the development costs.

Questions. The Subcommittee has requested the DHS to provide technical assistance on this issue by responding to the following questions.

1. **DHS**, Please briefly describe what would be needed to expand the program as noted.

2. Implementation of AB 121 Regarding Lead in Candy

Issue. The DHS is **requesting an increase of $1 million (General Fund) to support 8 new positions and purchase laboratory equipment to initiate activities for implementation of AB 121 (Vargas), Statutes of 2005.**

This legislation requires the DHS to regulate the lead content in candy by: (1) testing candy to determine whether it contains lead in excess of the adulteration level; **(2)** establishing procedures for use by candy manufacturers for testing and certifying candy as being unadulterated; **(3)** taking certain follow-up actions to ensue that adulterated candy would not e sold or distributed and **(4)** convening an interagency collaborative to serve as an oversight committee, and **(5)** to work with the Office of Environmental Health Hazard Assessment (OEHHA), part of the Cal-EPA, in establishing and revising the adulteration level of lead.

The DHS states that this request would also allow them to perform bilingual lead poisoning prevention education efforts and partner with Mexican government officials, with the assistance of the U.S.-Mexican Border Health Commission, in efforts to reduce lead in candy.

The 8 requested positions and their key functions are as follows:

- *Research Scientist II's (Two positions for Chemical Sciences).* These two positions would be used to (1) complete testing of candy samples, (2) perform quality assurance and control testing, (3) prepare audit reports and data summaries, and (4) provide consultation and training in testing methods to candy manufacturers and local health agencies.
- *Research Scientist II (Food & Drug Sciences).* This position would be used to (1) prepare and periodically revise protocols for statistical sampling and testing of candy, (2) evaluate lead test data received from the laboratories and determine whether follow-up sampling and testing would be necessary, (3) inform the Food and Drug Investigator of adulterated candy for enforcement actions, and (4) respond to questions from candy manufacturer's and consumers.
- *Research Analyst I.* This position would be used to (1) design and perform quantitative and qualitative data analysis tasks relating to the prevalence and incidence of lead in candy, (2) analyze and prepare statistical reports and summaries for the Legislature, media and the public on the surveillance data gathered from lead in candy investigations, (3) develop and use innovative research and statistical methods and techniques to perform a variety of data matching, analysis, trending, and statistical activities to determine prevalence of lead in candy, and (4) prepare reports of findings and forward surveillance data to the Interagency Collaborative.
- *Senior Food and Drug Investigator.* This position would be used to (1) collect regulatory samples, take enforcement actions and coordinate recalls of candy, (2) prepare documents for civil cases or administrative hearings on firms that sold or distributed adulterated candy, (3) respond to consumer and industry complaints

regarding candy, and (4) collaborate with Border Health Agency to identify firms in violation in foreign counties and to manage enforcement activities.

- *Laboratory Technician.* This position would be used to (1) prepare samples for testing, (2) Prepare reagents for testing, (3) store, maintain, and inventory retained samples, reagents, and replacement parts for instruments, and (4) prepare and send test results to the DHS Food and Drug Branch or other agencies under the direction of the Research Scientist II's (see above).
- *Staff Programmer Analyst II.* This position would be used to (1) maintain the programming for storing database information, (2) enter test results in the database, (3) generate and print test data in various formats upon receiving requests, and (4) post the test results and other information relating to lead in candy to the DHS' Food and Drug Branch website.
- *Associate Governmental Program Analyst.* This position would be used to (1) operate the Interagency Collaborative, (2) analyze the effectiveness of regulatory controls as related to the requirements of the bill, and (3) prepare status reports to the Interagency Collaborative regarding the implementation of the bill's requirements.

In addition, the DHS is requesting to expend $252,300 (General Fund) for equipment, including laboratory equipment, reagents, computer equipment, and public safety equipment. About $190,000 of the total amount is for the purchase of a Mass Spectrometer which is needed to measure the lead content in candy. Of the $252,300, only $60,000 would be ongoing expenditures for reagents and related materials.

The bill requires the cost for the activities to be funded in part or in whole by civil penalties imposed based on violations, test-related cost recovery from the manufacturer or distributor of adulterated candy, and grant funding. However, the Administration estimates that funding from these sources would be minimal and insufficient for implementing the newly mandated activities. Therefore they are proposing the use of General Fund support.

The DHS would have to establish procedures using OEHHA methods for the testing and certification of candy. As discussed below, the OEHHA will not be establishing these standards for at least two-years (i.e., 2008).

The DHS maintains that even if the OEHHA does not establish the required standard by July 1, 2006, the DHS still has requirements in AB 121 that must be addressed even if there are delays in the regulations defining "naturally occurring levels". Further the DHS notes they will still test candy at the existing 0.5 parts per million standard and take appropriate regulatory action.

In addition, the DHS has had discussions with the Attorney General's Office as part of the Proposition 65 litigation against certain candy manufacturers. **Based on these discussions, the DHS believes that a written determination from the Attorney General's Office will be available by July 1, 2006 or soon thereafter.**

Additional Background--Role of the Office of Health Hazard Assessment (OEHHA). AB 121, Statutes of 2005, requires OEHHA, part of Cal-EPA, to adopt regulations that identify a level of lead that is naturally occurring in candy with chili, tamarind or other ingredients that may contain high lead levels. OEHHA would also certify sampling and testing protocols, as well as serve on an interagency oversight committee. With respect to the regulations, AB 121 requires OEHHA to have them in place by July 1, 2006.

The OEHHA budget proposes an increase of $125,000 (General Fund) to fund a Research Scientist III and related operating expenses. It should be noted that this budget request states that OEHHA will *not* meet the July 1, 2006 date and in fact, says it will take them at least two years to identify a naturally occurring level and adopt it in regulation. **Senate Subcommittee #2 approved the OEHHA request.**

OEHHA notes that identifying naturally occurring lead levels is especially challenging for candy products produced in foreign countries, including Mexico. In many of these countries, lead contamination from human activities can vary significantly due to differing historic and continuing uses of lead. They contend that determining a naturally occurring level amounts to a significant academic undertaking that is impossible for OEHHA to complete within the six-month timeline provided for by the legislation. Therefore, they believe it is going to take them two years to complete the regulations.

Additional Background—DHS Activities. Under existing law, the DHS is responsible for administering and enforcing the Sherman Food, Drug and Cosmetic Law which prohibits the adulteration of food, or the manufacturing, selling, delivering, holding, or offering for sale of any adulterated food in California.

Although a relatively uncommon source of lead poisoning, some imported candies have been found to contain lead in excess of the maximum amount deemed safe for consumption by a child in one day. The DHS has issued seven public health advisories since 1993 (with the latest one being March 2004) regarding concerns with lead in candy.

In 2004 the DHS tested 167 imported candy samples and found 127 of them with measurable levels of lead, while 11 had lead levels that are deemed unsafe for consumption by current regulatory standards. This candy was embargoed and public health advisories were issued. Currently the DHS conducts analysis of candy for lead in only about 100 varieties of candy per year.

Subcommittee Staff Recommendation. It is **recommended to approve** the DHS proposal. Implementation of this legislation will assist in addressing an important public health concern.

Questions. The Subcommittee has requested the DHS to respond to the following questions.

1. DHS, Please briefly describe the budget request.

3. AIDS Drug Assistance Program (ADAP)—*Base Program*

Issue. The **budget proposes an increase of $28.1 million ($16.5 million General Fund) for the AIDS Drug Assistance Program** for total expenditures of $296.4 million ($107.7 million General Fund, $100.9 million federal funds, and $87.8 million in drug rebates). The proposed increase is based on actual ADAP expenditures through June 2005 and reflects ongoing cost trends for the program. The model to project expenditures is a linear regression model that has generally been used for the past few years.

The principle cost factors for ADAP are steadily increasing drug prices and an increasing client caseload. Over 80 percent of ADAP expenditures are spent on anti-retrovirals and 7 percent are spent on opportunistic infections. Individuals enrolled in the ADAP often continue in the program for longer periods since HIV/AIDS is a chronic illness, and other public and private healthcare are limiting prescription drug coverage. On average, ADAP clients access the program of 7.4 months per year.

Further, ADAP clients are now receiving more prescription medications per person than in past years. Drug resistance, the adverse health effects of long-term anti-retroviral therapy, and a need for increased anti-retroviral support all contribute to this increase. **It is estimated that ADAP will serve over 28,000 clients in 2006-07.**

Studies consistently show that early intervention and treatment adherence with HIV/AIDS-related drugs prolongs life, minimizes related consequences of more serious illnesses, reduces more costly treatments, and increases the HIV-infected person's health and productivity.

ADAP is cost-beneficial to the state. Without ADAP assistance to obtain HIV/AIDS drugs, infected individuals would be forced to (1) postpone treatment until disabled and Medi-Cal eligible, or (2) spend down their assets to qualify for Medi-Cal. **About 50 percent of Medi-Cal costs are borne by the state, as compared to only 28 percent of ADAP costs.**

Background—How Does the AIDS Drug Assistance Program Serve Clients? ADAP is a subsidy program for low and moderate income persons (individual income cannot exceed $50,000) with HIV/AIDS who have no health care coverage for prescription drugs and are *not* eligible for "no-cost" Medi-Cal Program.

ADAP clients with incomes between $39,200 (400 percent of poverty) and $50,000 are charged monthly co-pay for their drug coverage. A typical client's co-payment obligation is calculated using the client's taxable income from a tax return. The client's co-payment is the lesser of: (1) twice their annual state income tax liability, less funds expended by the person for health insurance premiums, or (2) the cost of the drugs.

Under the program, eligible individuals receive drug therapies through participating local pharmacies under subcontract with the statewide contractor. The state provides reimbursement for drug therapies listed on the ADAP formulary (about 154 drugs

currently). The formulary includes anti-retrovirals, opportunistic infection drugs, hypolipidemics, anti-depressants, vaccines, analgesics, and oral generic antibiotics.

Since the AIDS virus can quickly mutate in response to a single drug, medical protocol now calls for Highly Active Anti-retroviral Treatment (HAART) which minimally includes three different anti-viral drugs.

Background—ADAP Uses a Pharmacy Benefit Manager. Beginning in 1997, the DHS contracted with a pharmacy benefit manager (PBM) to centralize the purchase and distribution of drugs under ADAP. Presently there are about 238 ADAP enrollment sites and over 3,300 pharmacies available to clients located throughout the state.

Background—ADAP Drug Rebates (Federal and State Supplemental). Both federal and state law require ADAP drug manufacturer rebates to be paid in accordance with the same formula by which state Medicaid (Medi-Cal) programs are paid rebates. This formula is established by the federal CMS. Due to federal restrictions regarding the rebate calculation formula, the actual calculation (i.e., the specific multiplier) is not available to the state or the public. Therefore, the actual rebates California receives varies by the amount invoiced to the drug manufacturer.

California also negotiates additional supplemental rebates under ADAP via a special national taskforce, along with eight other states. The mission of this taskforce is to secure additional rebates from eight manufacturers of antiretroviral drugs (i.e., the most expensive and essential treatment therapies). The DHS has also begun to negotiate supplemental rebates on non-antiretroviral drugs.

Subcommittee Staff Recommendation. It is **recommended to approve the proposal**. It is likely that technical adjustments will be forthcoming at the May Revision to adjust the costs (more updated data), as well as revenues to be received from federal funds and drug rebate funds.

Questions. The Subcommittee has requested the DHS to respond to the following question.

1. **DHS**, Please provide a brief summary of the proposal.

4. Medicare Part D Drug Program and Individuals with HIV—*Proposed Changes*

Issue. California's ADAP also interacts with the implementation of the federal Medicare Part D Drug Program. *Medicare-only* clients with AIDS will have new cost burdens under Medicare Part D because of the complicated interaction between ADAP and the Medicare Part D Drug Program. **This complicated interaction is discussed further below.**

In order to address concerns with these interactions, constituency groups are requesting to use federal Title II Ryan White CARE Act funds to subsidize premiums for Medicare-only ADAP clients. The premiums would be paid out of the CARE-HIPP since this program exists to pay health care premiums for those who cannot otherwise afford them.

The DHS presently has the statutory authority to use federal Title II Ryan White CARE Act funds for premium assistance via CARE-HIPP but they contend they would need positions to address the workload needs.

It is assumed that this use of federal funds from ADAP would not be a concern because the annual premium cost for each individual would be about $279 for 2006 while each individual enrolled in Medicare Part D should save ADAP about $1,500 annually (i.e., Medicare pays 75 percent of the drug cost during the first level of Medicare coverage).

It is estimated that ADAP will save about $9.2 million because there will be 6,161 clients covered by the first level of Medicare Part D coverage. It is estimated that the total cost in 2006-07 to make premium payments is $1.3 million. This premium payment figure consists of costs for Medicare-only ADAP individuals and costs for Medi-Cal share-of-cost/Medicare ADAP individuals. **Therefore, there are funds available for the DHS to provide this premium assistance.**

However, no funding shifts are necessary for the DHS to expand CARE-HIPP. The DHS has existing statutory authority to use funds within the ADAP, when cost beneficial to the state (i.e., saves funds in ADAP). This is because it allows the state to use ADAP as the payer of last resort.

A similar comparison to this is how the state currently pays certain Medicare healthcare coverage premiums using the state's Medi-Cal Program when it is cost-beneficial for the state.

As a payer of last resort, ADAP clients who also have Medicare coverage (i.e., the Part D Drug benefit) are required to use their Medicare drug benefit first. These clients will likely turn to ADAP for assistance in "subsidizing" Medicare by meeting their out-of-pocket costs.

It is important to note that the Medicare HIV/AIDS population is different from the general HIV/AIDS population because these individuals have been disabled by their HIV infection and have survived the 29 month waiting period to qualify for Medicare.

Most people with HIV infection on Medicare are dealing with health care problems associated with advanced HIV disease, side effects from HIV treatment, and concurrent disease issues, including mental health issues. They often need multiple medications.

Background—Interaction of ADAP with Medicare Part D and its Complications. This section will discuss how the **ADAP has *evolved*** because of the implementation of the federal Medicare Part D Program as of January 1, 2006.

With the implementation of the federal Medicare Part D Program (January 1, 2006), ADAP serves the following segments of people:

- *People who have full Medi-Cal coverage (i.e., no share-of-cost), Medicare and proactively sign up for ADAP*. Prescription drug coverage for this group has moved from Medi-Cal to Medicare. ADAP covers the fixed co-pays ($1 to $5) required under Medicare Part D *only* for drugs on the ADAP formulary. There are about 9,239 people in this category (best estimate at this time). (Existing state statute provides for this.)

- *People who qualify for Medi-Cal with a share-of-cost (i.e., Medically Needy), Medicare and ADAP*. ADAP can no longer pay the Medi-Cal share-of-cost because it can only pay for drug coverage and drugs for these individuals are now provided through the Medicare Part D Program.

- *People who qualify for Medicare and ADAP.* Currently, people must sign up for Medicare Part D and pay their premiums before ADAP can continue assistance, as ADAP is a payer of last resort. ADAP can pay the deductible for drugs that are on the ADAP formulary. It can pay the co-insurance in the first level of coverage of the standard Medicare drug benefit for drugs on the ADAP formulary and it can provide coverage in the "donut hole" for the same drugs.

Before Medicare Part D, the ADAP served the following segments of people:

- *People who qualified for Medi-Cal through the Medically Needy Program (and had a monthly share-of-cost), Medicare and ADAP.* The ADAP paid the share-of-cost associated with prescription drug coverage, after which Medi-Cal covered the remaining prescription drug cost and some health care costs not covered under Medicare. There are about 3,100 people in this category (best estimate at this time).

- *People who qualified for Medicare and ADAP but had little or no prescription drug coverage. ADAP.* ADAP provided most or all of this population's prescription drug coverage. There are about 3,061 people in this category (best estimate at this time).

Background—CARE/HIPP Program. The federal Ryan White Comprehensive AIDS Resources Emergency (CARE) Act of 1990 established the Health Insurance Premium Payment (HIPP) Program under Title II of the Act. **This program pays health insurance premiums on behalf of people disabled by HIV/AIDS and at risk of losing their health insurance coverage.**

California's CARE/HIPP budget consists of an annual allocation of $1.7 million (federal Ryan White CARE Act Title II funds). Recent research has shown that for every $1 of CARE/HIPP money spent, Medi-Cal and ADAP save about $8.

In California, individuals are eligible for CARE/HIPP if they meet the following requirements: (1) resident of California; (2) are disabled by HIV/AIDS; (3) have assets less than $6,000; (4) have income less than 400 percent of federal poverty; and (5) have a monthly insurance premium less than $500. **Clients may remain on CARE/HIPP for 29 months, and must recertify eligibility every three months.** Since its inception, CARE/HIPP has served over 3,000 clients (since 1990). **Presently there are about 457 clients being served.**

Subcommittee Staff Recommendation. It is recommended to provide an increase of $182,000 (General Fund) to provide two Associate Governmental Program Analyst's to the Office of AIDS to support the cost-beneficial expansion of the CARE HIPP to provide assistance to individuals using ADAP and the Medicare Part D Program because it is cost-beneficial to the state.

Questions. The Subcommittee has requested the DHS to respond to the following questions in order to provide technical programmatic assistance.

2. **DHS**, Would it be cost beneficial to expand the CARE HIPP to provide assistance to Medicare Part D individuals to maintain cost effectiveness in ADAP?

5. Proposed Expenditure of New Federal Pandemic Influenza Funding—*CY & BY*

Issue—Receipt of Section 28 Letter. On April 27th the Administration submitted a Section 28 Letter to the Joint Legislative Budget Committee (JLBC) **regarding the expenditure of $ 6.7 million in *one-time only* supplemental federal funds from the federal Centers for Disease Control (CDC) to prepare for and respond to an influenza pandemic.** The $6.7 million (federal funds) must be encumbered by August 31, 2006 and does *not* require any state matching funds. The federal CDC had notified states in mid-January of the availability of these funds but did not provide federal guidance until March.

The Administration's expenditure proposal affects both the current-year and budget year. The current-year would expend $877,000 (federal funds) and the budget year would expend $5.8 million (federal funds). **These are discussed separate below.**

SB 409 (Kehoe) and the Current Year Section 28 Proposal. The Administration's current-year proposal for pandemic flu was discussed and evaluated through the Budget Subcommittee process, as well as the policy committee process. From these discussions, SB 409 (Kehoe) was crafted. **This legislation was passed by the Legislature and sent to the Governor on May 4th.**

The Administration's Section 28 letter does not affect the current-year appropriations contained in SB 409, but it does propose to expend federal funds in areas that are **still pending budget deliberations *and* affect the budget year. In addition, it proposes to expend federal funds on certain requirements as directed by the federal CDC.**

In a May 5th letter to the DOF, Senator Chesbro notes that some of the proposals are premature for the current year given that the issues are still being discussed for budget year purposes and were intentionally absent from SB 409 for this reason.

As noted in the letter, Senator Chesbro was advised by the LAO that it is possible to obligate a portion of the new federal funds for other eligible pandemic influenza purposes in 2006-07 (by August 30, 2006) so that they would not be lost by the state.

Given this perspective, Senator Chesbro informed the DOF that only $290,000 (federal funds) would be approved for the current year and the remaining amount $587,000 (i.e., $877,000 less $290,000) be used instead as part of deliberations on the 2006-07 budget in this area.

The following table depicts the detailed affect of this JLBC recommendation.

Table—Administration's Section 28 and Response of the JLBC *(Proposed Changes)*

Topic	Governor's January (Current Year)	Section 28 Letter (Current Year)	JLBC Response (Current Year)
Pandemic Flu Preparedness (PS 03)	5 positions (partial) $272,000 GF	5 positions (May-June) **$108,000 federal** $164,000 GF	**Deny.** These positions are under discussion in the budget year.
State Support for Local Health Preparedness (PS 61)	5 positions (partial) $213,000 GF	5 positions **$101,000 federal** $112,000 GF	**Deny.** Under discussion in budget year.
Consultant--Training for locals (PS 61)	$127,000 GF	**$63,411 federal** $63,589 GF	**Deny.** Under discussion in budget year.
Public Education and Media: • "in" reach/outreach • Emergency Hotline • Public Media • State Staff (5 positions) (PS 62)	 $250,000 GF $500,000 GF $2,050,000 GF $221,000 GF	 **$125,000 federal** $125,000 GF **$100,000 federal** $400,000 GF $2,050,000 GF **$90,000 federal** $131,000 GF	**Deny.** Under discussion in budget year.
Subtotals	$3,633,000 GF	**$587,411 federal** $3,035,589 GF	**$587,411 federal (deny)** GF not funded in CY
New Federal Requirements:			
• Exercise pandemic flu plans and procedures		$50,000 federal	Approve, waive 30-days
• Operational emergency notification plan		$100,000 federal	Approve, waive 30-days
• Collaboration--other states, trial entities, Mexico, & military		$100,000 federal	Approve, waive 30-days
• Pandemic Flu Summit		$40,000 federal	Approve, waive 30-days
Subtotal Federal Requirements		**$290,000 federal**	**Approve all projects**
Total Federal Funds, Section 28		**$877,411 federal**	**Deny $587,411 and Approve $290,000**

Budget Year Section 28 Proposal. **As noted in the table below, the Administration is proposing to use about $5.5 million to offset General Fund support for certain activities as contained in the Governor's January budget for 2006-07. (The table below only shows proposed changes as affected by the Section 28.)**

Table—Administration's Budget Year *Changes* to Reflect New Federal Funds

Topic	Governor's January Budget 2006-07	Section 28 2006-07 (To be May Revision)	Prior Action Of Subcommittee
Pandemic Flu Preparedness (PS 03)	5 positions $673,000 GF	5 positions **$58,000 federal** $615,000 GF	Held **open**—See Agenda item #6 below.
Local Health Preparedness—61 areas (PS 61)	$16 million GF	**$4,506,245 federal** $11.5 million GF ($100,000 each, then population based)	• $9.150 million GF ($150,000 minimum, then population based) • $6.850 million-**open**
State Support for Local Health Preparedness (PS 61)	5 positions $497,000 GF	5 positions **$111,000 federal** $386,000 GF	Reduced by 2 positions
DHS consultant contracts: • Training for locals • Technical assistance (PS 61)	 $1 million GF $382,000 GF	 $1 million GF **$63,411 federal** $318,600 GF	Approved $1 million GF & rejected $382,000 GF No need for $63,411 fed
Public Education and Media: • "in" reach/outreach • Emergency Hotline • Public Media • State Staff (5 positions) (PS 62)	$1,000,000 GF $1,300,000 GF $11,476,000 GF $518,000 GF	**$200,000 federal** $800,000 GF **$100,000 federal** $1,200,000 GF $11,476,000 GF **$98,000 federal** $420,000 GF	Denied entire request in March 13th hearing.
Workforce Capacity—field investigators	$350,000 GF	**$350,000 federal**	$350,000 federal (our action already did)
Subtotal GF Offsets from Fed		**$5,486,656**	N/A—actions pending
New Federal Requirements:			
• Exercise pandemic flu plans and procedures		$120,000	
• Collaboration with other states, trial entities, Mexico and our military		$100,000	
• CAHAN hardware expansion to accommodate more users		$139,140	
Subtotal Federal Requirements		**$359,140 federal**	
Subtotal GF Offset to Budget		**$5,486,656 federal**	
Total Federal Dollars---BY		**$5,845,796 federal**	

Subcommittee Staff Recommendation. ***First***, it is recommended to utilize the $587,000 in federal funds not to be expended for the current-year as directed by the JLBC, to off-set General Fund support in the budget year. These funds can be use for various purposes relating to pandemic flu; however, for ease of tracking the expenditure, it is recommended to use this $587,000 in one area and to use it to off-set state support costs. **Therefore, it is recommended to designate these funds for the proposal to "expand local and statewide communicable disease surveillance infrastructure" (PS-32) ($1.3 million GF) which was approved by the Subcommittee on March 13th. Specifically, the $587,000 would be used to offset a corresponding portion of the General Fund.**

Second, it is recommended to approve the request to provide $359,140 (federal funds) for the new "federal requirements" as shown on the chart and as required by the federal CDC.

Third, it is recommended to approve the proposed $4,506,245 (federal funds) amount for Local Health Jurisdictions as an augmentation to the prior Subcommittee action. The total amount of this proposed action would be to provide **$13.656 million** ($9.150 million General Fund and $4.506 million federal funds) to the locals. **In addition, it is recommended to adopt place holder trailer bill legislation that would allocate the $9.150 million based on the $150,000 minimum per local jurisdiction,** in lieu of the Administration's $100,000 minimum for this particular purpose.

It should be noted that under the Administration's revised proposal, a total of $16 million ($11.5 million and $4.506 million federal funds) would be provided, with $6.1 million allocated based on a $100,000 minimum and the remaining amount of almost $10 million being allocated based on population.

Fourth, the following technical adjustments are proposed to use the remaining federal funds as follows:

- Use the $111,000 (federal funds) for "State Support for Local Health Preparedness (PS 61)" in the same manner as the Administration proposes. This will offset the General Fund support for the Subcommittee's prior action on this issue (approved 3 of the five positions).
- Use $461,411 (federal funds) from those items previously denied by the Subcommittee (i.e., Administration's expenditures for some contracts, media campaign package) and use it to offset General Fund support for the $1 million in consultant contracts to assist the locals (PS 61).

Questions. The Subcommittee has requested the DHS to respond to the following questions.

1. **DHS**, Please provide a brief description of the funding changes, and a brief overview of the new federal requirements.

6. Assuring Pandemic Influenza & Disease Outbreak Preparedness & Response *("Open" Issue*)

Prior Subcommittee Action—Held "Open". This issue was discussed in our **March 13th** hearing and was held "open" pending further discussion. This proposal is part of the Administration's overall pandemic influenza package.

Issue & Proposed Revision per Section 28 Letter. The Governor's January budget requested an increase of $673,000 (General Fund) to fund 5 new, permanent positions to prepare for and respond to pandemic influenza**.** The Administration is now proposing to off-set $58,000 of this amount by using federal funds. **Therefore, the revised funding is $673,000 ($615,000 General Fund and $58,000 federal funds).**

The requested positions would conduct epidemiologic investigations of influenza and respiratory infectious disease outbreaks, and provide epidemiologic and statistical support to the department. **The requested positions and their intended purposes are as follows:**

- *Immunization Branch (4 positions).* A total of four positions--Public Health Medical Officer, Nurse Consultant III, Research Scientist and Health Program Specialist—would be used to do the following key tasks:
    - Review state and national pandemic plans and develop standards for clinical activities that should be included in local pandemic influenza plans.
    - Communicate and coordinate with local, state and federal agencies and provide technical assistance.
    - Work with health care partners and other sources of influenza data to develop methodologies to evaluate influenza illness and vaccination coverage.
    - Research clinical care settings, including staffing, equipment and infrastructure to measure availability of surge capacity for an outbreak.
    - Develop standards of care for a clinical response to pandemic influenza, including antivirals, and vaccine prioritization strategies.
    - Conduct investigations of epidemiology and coordinate a statewide network of local and regional clinicians, epidemiologists and public and private laboratories to facilitate influenza activities.

- *Infectious Disease Branch (one position).* A Research Specialist III position would be used to provide epidemiologic and biostatistical support for the surveillance, prevention and control of influenza and respiratory disease outbreaks in coordination with the infectious disease laboratories.

The DHS states that these positions are necessary because they presently do not have the capacity to implement onsite epidemiologic investigation, or to provide the level of expertise required in the event of a pandemic influenza outbreak in California. They contend that these positions are needed to provide active planning

and development of policies, procedures model emergency orders and risk communication strategies in order to prepare for any pandemic event.

Legislative Analyst's Office Recommendation--Deny. The LAO contends that the DHS could utilize existing positions, funded using federal bioterrorism funds, for these purposes.

Subcommittee Staff Recommendation. It is recommended to modify this proposal to provide **a total of three staff**—the Public Health Medical Officer, Nurse Consultant III, and Research Scientist positions for the Immunization Branch. This would reduce the request by about $200,000 (General Fund). **Therefore the total appropriation would be about $473,000 ($415,000 General Fund and $58,000 federal funds).**

These positions would provide assistance to local health jurisdictions from an operational standpoint, by providing scientific and medical expertise. **Currently, the DHS responds to flu and respiratory infection outbreaks on an ad hoc basis.**

Questions. The Subcommittee has requested the DHS to respond to the following questions:

1. **DHS**, Please provide a brief summary of the proposal and how these positions are different than other positions being utilized within the department presently, or contained in other budget proposals.

7. Preparedness for Chemical and Radiological Disasters and Terrorist Attacks

Prior Subcommittee Action—Held "Open". This issue was discussed in our **March 13th** hearing and was held "open" pending further discussion and to see if other special funds or fees could be used in lieu of General Fund support. These options are discussed further below.

Issue. The budget proposes **a total increase of $4.2 million (General Fund) to support 15 new, permanent positions, hire consultant staff and purchase equipment to prepare for chemical and radiological disasters and attacks on (1) the environment, (2) food, and (3) water.** The proposed equipment costs are $880,000 and the consultant expenditures are $1.3 million. Both of these costs are contained within the $4.2 million amount.

The funding and positions can be *generally* segmented into the following areas:

- *Environment.* A **total of $1.2 million** (General Fund) and 4 positions (Research Scientist I, Research Scientist II, Research Scientist III, and a Health Education Consultant III) are identified for this function.
- *Food.* A total of **$1.6 million** (General Fund) and 6 positions (two Associate Health Physicists and four Research Scientist IV's)
- *Water.* A total of **$1.4 million** (General Fund) and 5 positions (all Associate Sanitary Engineers)

According to the DHS, these resources would be used to do the following key functions:

- Develop plans and support training for public health responses to chemical and radiological contamination resulting from disasters and terrorist attacks;
- Develop food and water protection plans against intentional contamination with chemical and radiological agents;
- Provide training to local jurisdictions and the food industry; and
- Enhance laboratory capability to rapidly and accurately identify chemicals and radiological agents contaminating food, water and the environment in disasters and terrorist attacks.

According to the DHS, funding for chemical and radiological terrorism preparedness has focused traditionally on first responders. **The DHS notes that federal funds received from the federal Centers for Disease Control and other agencies have *not* provided funding to cover planning, preparing, training, and exercising in response to chemical or radiological terrorism.** As such, the DHS believes that resources are needed to establish minimum capabilities for preparedness and response to chemical or radiological attacks.

Legislative Analyst's Office Recommendation. The LAO makes the following recommendation regarding the three aspects of this proposal:

- *Environmental ($1.2 million and 4 positions).* The LAO recommends **approval** of this component as proposed, including the use of General Fund support.
- *Food ($1.6 million and 6 positions*). The LAO recommends **shifting these expenditures from General Fund support to fee supported.**
- *Water* ($1.4 million and 5 positions). The LAO has changed their recommendation to approve these positions using the Safe Drinking Water State Revolving Fund, as discussed below.

New Updated Information—Options for Fees and Special Fund Use. At the request of the Subcommittee, the DHS provided technical assistance information as to how fees would likely be adjusted if fees were used to fund the DHS request in lieu of General Fund support for the "environmental" proposal and for the "food" proposal. Based on this information, fees would need to be increased in 2006-07 and 2007-08 for food retailers, food processors, and radioactive material facilities (See Hand Out).

In addition, the DHS has informed Subcommittee staff that federal funds deposited in the Safe Drinking Water State Revolving Fund could be used to fund the water component of this proposal. The LAO concurs with this aspect.

Subcommittee Staff Recommendation. It is recommended to **(1)** approve the environmental component for $1.2 million General Fund and 4 positions (same as LAO); **(2)** reject the food component for $1.6 million General Fund and 6 positions, and **(3)** approve the water component but use the Safe Drinking Water State Revolving Fund in lieu of General Fund support (same as LAO).

First, the environmental component would provide an initial framework to commence with more comprehensive work in this area which has been somewhat overlooked since federal bioterrorism funds were authorized for use in this area.

Second**,** the food component is not as a compelling need since California already has a comprehensive food, drug and agriculture "protection" program, and food processors also have taken steps to help ensure safety measures. Further as noted in the Hand Out, the level of fee increase that would be required to sustain the food component is likely more than the industry may be willing to pay for this type of assistance. Therefore, it is recommended to deny the component completely.

Third, it is recommended to approve the 5 positions for the water component using federal funds that are deposited in the Safe Drinking Water State Revolving Fund, but to make the positions **two-year limited-term**. This will provide the Legislature with the ability to revisit the use of these funds for these positions at that time.

Questions. The Subcommittee has requested the DHS and LAO to respond to the following questions.

1. **DHS**, Please provide a brief summary of the request.
2. **LAO**, Please present your recommendation.

8. Implementation of AB 1876, Statutes of 2004—*Funding Needed*

Issue. AB 1876, Statutes of 2004, added San Francisco Bay beaches into the state's public health water quality monitoring program originally established for Southern California beaches (i.e., AB 411, Statutes of 1998). **Funding was *not* provided in the Governor's budget to appropriately monitor San Francisco Bay as contained in the legislation.**

***Prior* to AB 1876, Bay Area Counties had been *ineligible* for state funding for water quality monitoring at beaches.**

The program requires County Health Departments to test for bacteria once a week from April to October at beaches which have 50,000 or more annual users and are located adjacent to a storm drain or other outfall. If bacteria levels pose a threat to public health, counties are required to post easy-to-understand signage advising residents of the risks.

Counties are required to monitor beaches *only* in years when the state provides funding from the DHS local assistance. These state funds are committed to the counties in cycles of three-year contracts. **The budget year will be the first year of the next three-year cycle.**

The DHS proposes the following expenditures in the budget year for specified coastal counties and related beach areas:

Table: DHS Beach Sanitation Funding

Coastal County	Funding Level
San Diego County	$336,129
Orange County	208,904
Ventura County	158,999
Los Angeles County	72,335
Santa Barbara County	57,486
Monterey County	35,900
Sonoma County	31,234
San Luis Obispo County	26,662
Santa Cruz County	22,100
San Mateo County	9,463
San Francisco City/County	*0*
Total for 2006-07	**$959,212** **General Fund**

Human sewage and urban runoff contribute bacteria to beach waters, which is a known health risk to people who have direct water contact, especially children. Water quality testing provides a safety net against the worst public health dangers to people who swim in the Bay. Residents have a right to know if the water poses a threat to their health, and testing/signage programs allow them to make informed choices. Only consistent, long-term monitoring data can identify chronic contamination "hot spots".

Subcommittee Staff Recommendation. It is recommended to appropriate $100,000 to the DHS Beach Sanitation program for San Francisco Bay to be monitored as other coastal areas are monitored, and as provided for in AB 1876.

9. Administration's Proposal for Proposition 99 Funding—*DHS Portion*

Issues. The Governor's budget proposes *a series of adjustments* to various programs funded with Proposition 99 Funds. These adjustments vary from year to year contingent upon the variability of the revenues, caseload adjustments to programs, other technical adjustments, and policy priorities. As referenced below, expenditures are also strictly guided by the Proposition 99 Fund designated accounts and can only be spent for specified purposes.

Key Program Changes as Proposed by Governor. The following key adjustments for DHS-operated programs are as follows:

- *Asthma.* The budget proposes an increase of $1 million for certain Asthma activities for a total appropriation of $4 million. **Of the requested $1 million, almost $600,000 of it is to support 5 new positions. The Administration had proposed last-year's Asthma funding as *one-time* only. (This issue is discussed below.)**
- *Orthopedic Hospitals Settlement.* The budget increases by $17.7 million (from $25.8 million to $43.5 million) the amount of Proposition 99 funds used to support the Orthopedic Hospitals Settlement agreement to continue to provide increased rates for hospital outpatient services. This appropriation services as a General Fund off-set. (No issues have been raised regarding this change.)
- *CA Healthcare for the Indigent Program.* The Administration decreases the program by $21 million for total expenditures of $45.2 million. The DHS states that the main reason for this decrease is that the program was provided a one-time only increase last year due to robust revenues. (No issues have been raised regarding this change.)
- *Rural Health Services.* The Administration decreases the program by $2.5 million for total expenditures of $4.7 million. The DHS states that the main reason for this decrease is that the program was provided a one-time only increase last year due to robust revenues. (No issues have been raised regarding this change.)
- *Media Campaign.* The Administration proposes an increase of $4.3 million for total expenditures of $20 million (Health Education Account). These funds are to be used for (1) low socio-economic status population ($2.5 million); (2) Spanish language population ($1 million); and (3) Asian language population ($800,000). (No issues have been raised regarding this change.)
- *Competitive Grants.* The DHS proposes an increase of $1.3 million to (1) fund a smoking cessation center to provide training and technical assistance on cessation services throughout California to healthcare organizations and others, and (2) provide new and innovative educational materials for priority populations. (No issues have been raised regarding this change.)

- *Evaluation.* The budget proposes an increase of $1.9 million to primarily conduct data collection and to do studies of tobacco use in certain populations, such as American Indian/Native American, Filipino and other populations. (No issues have been raised regarding this change.)

Asthma Activities—Current Year. In the Budget Act of 2005, **a total of $3 million** (proposed as one-time only) was appropriated for various activities related to Asthma. The DHS notes that though all of the $3 million is encumbered in contracts, about $750,000 or so will not be expended in the current years (by June 30, 2006). According to the DHS, **in the current year**, the funds are being expended as follows:

- $735,000 to support 21 local childhood asthma projects. The DHS notes that these were awarded late in 2005 and are well on their way.
- $264,000 is an augmentation of an existing contract with Impact Assessment, Inc. who provides technical assistance to community organizations in the management and prevention of asthma, conducts asthma prevalence analysis, and manages some "mini-grants" with entities to reduce disparities in asthma diagnosis.
- $51,000 is allocated for "mini grants" to fund asthma disparities and to print special fact sheets regarding asthma.
- $578,000 to contract with UC San Francisco to assist with local project oversight in providing asthma education and care coordination services and with utilizing continuous quality improvement strategies to improve the delivery and quality of clinical asthma care.
- $985,000 for an interagency agreement (just executed in March 2006) with San Francisco State University to (1) provide technical assistance to the projects, (2) conduct various investigations regarding asthma, such as asthma co-morbidity and co-mortality in health problems such as obesity, tobacco smoking and hypertension; (3) train school personnel in environmental triggers of asthma; (4) support an asthma related telephone assistance, and (5) various other types of education, training and related items.

Proposed $1 million Expansion of Asthma Activities. The DHS is proposing an increase of $1 million to (1) hire 5 DHS staff at an estimated cost of $560,000, (2) augment contracts for asthma surveillance activities, and (3) expand the number of local sites to include five to seven more areas (about $350,000) and to possibly expand some additional service sites.

Background—Proposition 99. Proposition 99, the Tobacco Tax and Health Protection Act of 1988, established a surtax of 25 cents per package on cigarettes and other tobacco products, and provided a major new funding source for health education, indigent health care services, and resources programs. Under the provisions of Proposition 99, revenues are allocated across six accounts based on specified percentages. These are: (1) Health Education Account—20 percent, (2) Hospital Services Account—35 percent, (3) Physician Services Account—10 percent, (4) Research Account—5 percent, (5) Unallocated Account—25 percent, and (6) Public Resources Account—5 percent (in Subcommittee #2).

Subcommittee Staff Recommendation. It is recommended **to deny the $1 million** (Proposition 99 Funds—Unallocated Account) and the 5 DHS positions for the Asthma project, and instead**, redirect this amount to assist in funding the Rural Health Services Development Clinic Program and the Seasonal Agricultural Migratory Worker Program ($500,000 each).** Expending Proposition 99 Funds for these two clinic programs is one of the core concepts to the Proposition---to fund uncompensated health care costs.

The existing $3 million for the Asthma activities should continue; however, expansion of the $1 million at this time, particularly for permanent state staff, seems premature. Several components, as noted above, will not be expending their current year appropriation and some activities will continue to be gradually phased-in over the budget year since it just started last year.

Core health care programs, such as these clinic programs need assistance to continue to provide care for the uninsured. The Rural Health Services Development Clinic Program presently receives $8.2 million (General Fund) and supports about 122 clinics in rural areas throughout California. The Seasonal Agricultural Migratory Worker Program receives $6.9 million (General Fund) and supports 79 clinics. Both of these programs have proven their importance in providing communities direct access to primary health care.

Questions. The Subcommittee has requested the DHS to respond to the following questions.

1. **DHS,** Please provide a summary of the budget request.

10. Medi-Cal Redetermination Form Simplification—*Local Assistance*

Issue. The DHS has been in the process of modifying the Medi-Cal redetermination form to make it easier for Medi-Cal enrollees to complete and maintain their enrollment. **An increase of $42.1 million ($21.1 million General Fund) is proposed to reflect an increased caseload of 27,672 enrollees, or an additional two percent per month retention rate, due to these form changes.** With more user friendly forms available, it is anticipated that more Medi-Cal enrollees who may not have otherwise completed their redetermination forms, now will complete them.

In addition, an increase of $3.3 million ($1.7 million General Fund) has also been provided for County Medi-Cal Administration processing for these applications.

Subcommittee Staff Recommendation. The revised redetermination form is long over due. Many analyses of the Medi-Cal Program have cited the need for revised forms in order to facilitate retention and to mitigate against unnecessary administrative processing expenditures. **It is recommended to approve the proposal.**

Questions. The Subcommittee has requested the DHS to respond to the following questions.

1. DHS, Please provide a brief summary of the proposal.

11. Reduction to County Administration for Processing of Medi-Cal *(See Hand Out)*

Issue. The **DHS proposes a reduction of $42.4 million ($21.2 million General Fund) by freezing county administration salaries and overhead (such as utilities, rent, postage, energy costs, and others) at the 2005-06 level for 2006-07.**

In addition to this proposed cost freeze, **the Administration proposes to hold counties financially responsible for any federal penalties or disallowances that result from the failure of the counties t comply with requirements of the Medi-Cal Program. The penalty would be imposed by reducing the allocation of state funds to the county for eligibility determinations.**

Background—County Performance Standards. Through SB 26 (First Extra Ordinary Session), Statutes of 2003, the Legislature enacted comprehensive "county performance standards". Under these standards, counties must meet specified criteria regarding completing eligibility determinations and performing timely re-determinations. Specific work standards—including timeframes and percentages that need to be completed—are outlined in the enabling statute. **If a county does not meet these performance standards, their administrative funding may be reduced by up to two percent as determined by the Department of Health Services. Further, implementation of a corrective action plain in those counties that fail to meet one or more of the standards are required.**

The county performance standards address requirements for **(1)** Medi-Cal eligibility application processing, **(2)** Medi-Cal annual redetermination processing, and **(3)** bridging processing which is used to shift children from Medi-Cal to Healthy Families and back as appropriate due to different program eligibility standards.

As contained in the Medi-Cal Estimate for 2006-07, these ongoing county performance standards are estimated to save about $445.7 million ($222.8 million General Fund).

The DHS states that it received 4 positions (two permanent and two limited-term) for this purpose.

Background—County Cost Containment Plans. Through the Budget Act of 2004, and accompanying trailer bill language, the DHS in collaboration with the County Welfare Directors Association were directed to develop options and recommendations for modifying the budgeting and allocation methodologies for county Medi-Cal administration. Recommendations from this process were provided to the Legislature in 2005.

A principle component of the cost containment plan is the application of productivity standards in determining the number of eligibility workers needed for the Medi-Cal determination process which is based upon a county's computer consortia. **The Governor's budget reflects savings of $5.6 million ($2.8 million General Fund) for this purpose.**

Background—Medi-Cal Eligibility Determination System (MEDS) Reconciliation. Additional standards were implemented in the Budget Act of 2003, and accompanying trailer bill language to ensure that counties were appropriately reconciling their Medi-Cal eligibility files with the state's system. This included the establishment of standards regarding the processing of error "alerts", as well as submitting quarterly reconciliation files to the DHS for data verification and correcting any subsequent identified errors. **If a county fails to follow these standards, the DHS will request a Corrective Action Plan from the county. If the county fails to meet the Corrective Action Plan's benchmarks, the DHS may reduce the county administrative allocation for Medi-Cal by two percent.**

Background—Medi-Cal Eligibility Processing. Each county is responsible for implementing Medi-Cal eligibility and for interpreting state guidance on policies and procedures. Counties determine eligibility for Medi-Cal under a set of complex rules that require staff to collect and verify a variety of information. **In fact the DHS provides counties with a 900-plus page state Medi-Cal Eligibility Procedures Manual that is updated on a constant basis through state issued "All County Letters". There are more than 150 aid codes, and dozens of state Medi-Cal related forms.**

Counties are provided with an annual allocation from the state to conduct Medi-Cal Program eligibility processing activities for the state (federal law requires that a governmental entity complete all Medicaid (Medi-Cal) applications.) The allocation is contained within the annual Medi-Cal Estimate Package provided to the Legislature as part of the annual budget deliberations. The budget proposes expenditures of about $1.3 billion (total funds) for county administration of the Medi-Cal Program.

County-Based Constituency Organization's Request. The Subcommittee is in receipt of a letter that **(1)** requests denial of the Administration's proposal, and **(2)** adoption of placeholder trailer bill language to fund the **actual** cost to counties to administer both human services and Medi-Cal beginning in 2007-08.

Among other things, the letter notes that counties provide important services to their local constituents while serving as an arm of the state. Further, County Counsels' Association has opined that not funding increases to counties for costs to administer programs on behalf of the state amounts to a cost shift triggering the mandate reimbursement provisions of Proposition 1A.

The County Welfare Directors Association (CWDA) appropriately notes the inconsistency of the DHS by proposing to cut funding for county Medi-Cal operations while leaving all statutory performance requirements intact.

Legislative Analyst's Office Recommendation. The LAO **recommends to reject the Administration's proposal, including the trailer bill language.** They note that the Governor's proposal essentially delegates the decision about whether to reduce service levels in the face of inflationary cost pressures to the counties. County decisions will vary based on their priorities and their individual fiscal situations. Therefore, inconsistent

policies would likely occur across counties for Medi-Cal which is a state responsibility to operate consistently, as directed by both federal and state law.

Subcommittee Staff Recommendation. It is **recommended to reject the Administration's entire proposal and to restore the $42.4 million ($21.2 million General Fund) to appropriately fund the counties for their work.**

Counties administer Medi-Cal as an agent for the state with the aim of meeting state established program goals. Unless the counties elect to use their own general purpose revenues to backfill for the lack of state funding, Medi-Cal services related to eligibility processing would erode. This includes the need to conduct timely processing for annual redeterminations which ensures the integrity of the program, as well as keeps Medi-Cal expenditures down. (For example, a managed care plan could be receiving a monthly payment from the state for a Medi-Cal recipient who is no longer eligible.)

As noted above in the background sections, the state achieves annual savings of about $222.8 million (General Fund) from the county performance measures. In order for the counties to meet these performance standards, they need to be funded appropriately to meet the goals the state has established. Further, the DHS needs to do more work on the County Cost Containment Plans process as directed through trailer bill legislation two years ago.

Given the level of continuing savings the state has achieved by appropriately funding county administration so performance measures can be sustained, scaling back from this endeavor is fiscally imprudent.

Questions. The Subcommittee is requesting the DHS to respond to the following questions.

1. DHS, Please provide a brief summary of the proposal.

12. DHS Staff to Audit County Administration—New Positions

Issue. The DHS **is requesting an increase of $506,000 ($253,000 General Fund) and 5 new permanent positions to conduct on-site fiscal reviews to verify the accuracy of Medi-Cal claimed costs in each of the 58 counties.** The DHS states that this request is based on the need to improve their county allocation process by incorporating the results of county reviews in the county administrative funding process.

They contend that more substantial reviews will assist them in developing a more detailed process. The review's scope of work would consist of a review of the quarterly claims for each county, examination of supporting financial documentation and review of the county's compliance with performance standards. **Currently, there are 35 existing staff, including managers, conducting Medi-Cal program reviews.**

The requested DHS positions and their key activities are as follows:

- *Associate Governmental Program Analysts—4 Requested.* These positions would be used to perform on-site reviews in 58 counties. After an initial review of all of the

counties, the subsequent reviews will be staggered based upon size of the county (i.e., large counties reviewed annually, medium counties reviewed every two years, and small counties reviewed every three years). Activities would include (1) on-site review of documentation, (2) analyze data and prepare findings, and (3) review corrective plans and conduct follow-up to verify that the corrections are implemented.

- ***Staff Services Manager I.*** This position would serve as the manager of the unit. Activities would include (1) review staff's findings and the performance standards of the counties, (2) examine the Medi-Cal costs and documentation supporting costs, (3) oversee the fiscal analysis of the costs claimed, (4) confer with counties regarding audit issues, and (5) supervise and train new staff.

Background—Other DHS Oversight of Counties. In *addition* to the county performance standards and MEDS reconciliation as discussed in item 11 above, the DHS also conducts (1) Quality Control Reviews, and (2) Focused Reviews.

First, the state's agreement with the federal CMS requires that Medi-Cal case samples from counties be selected and reviewed by the DHS on a monthly basis. For the current year, the DHS is to review about 2,700 cases in order to determine the extent to which errors have occurred. Counties participate in these case reviews as partners of the state and work with state staff to identify and correct deficiencies.

Second, each year the DHS conducts "focused reviews". The topics for these focused reviews are based on information obtained from the Quality Control Reviews, as well as areas of interest to the DHS, such as newly implemented law or policy changes. Counties are reviewed on these chosen topics and work with the state to correct any errors or oversights in their implementation and interpretation of state policy and requirements.

Legislative Analyst's Office Recommendation—Approve Only 3 Positions. The LAO recommends to reduce the requested 5 positions **by deleting two of the AGPA positions for savings of $202,000 ($101,000 General Fund).** Their analysis indicates that the additional workload would only require three positions (i.e., two AGPAs and the Staff Services Manager I).

Subcommittee Staff Recommendation—Concurs with LAO. Subcommittee staff **concurs with the LAO recommendation to provide only three positions.** The workload does not justify the five positions. The analyses conducted by the DHS county performance standards staff should facilitate the on-site reviews of the counties. In addition, other reviews are presently conducted and the DHS section has 35 existing positions presently. A reasonable amount of core work has already been completed by these other staff.

Questions. The Subcommittee has requested the DHS to respond to the following questions.

1. DHS, Please provide a brief summary of the request.

13. Medi-Cal Managed Care--*Discussion for Informational Purposes*

Issue. There are numerous reports from health research that clearly indicate that the rates paid to medical providers can, and often do, affect the quality of care and access to care provided to Medicaid (Medi-Cal) patients. **Yet issues abound as to the methodology and actuarial soundness of the rates paid under the state's Medi-Cal Program, both in the Fee-For-Service Program and in Medi-Cal Managed Care.**

Many of these issues have evolved over time due to **(1)** incomplete, inaccurate and unreliable data for which to base rates on, **(2)** establishing rates based upon the availability of General Fund support, **(3)** varying definitions of what constitutes "actuarial" soundness, **(4)** a lack of clarity on how to link quality of care with rates, **(5)** difficulties in discerning health plan financial viability, and profit margin factors, **(6)** a need to trend data in an accurate manner, and many, many others.

The DHS is undertaking a financial review of the Medi-Cal Managed Care Plans and has hired a contractor to conduct different analyses to better discern how to craft workable, actuarially based rates. However, many issues need to be addressed in a short period of time in order to maintain the viability of the Medi-Cal Managed Care Program, including the expansion to the 13 new counties as has been previously discussed.

A rational approach to establishing the rates needs to be crafted and applied equability across plans. **Clarity is clearly lacking in the existing process. What measures does the DHS use to make rate decisions?**

For example, the Legislature appropriated a $ 5million ($2.5 million General Fund) rate adjustment for San Diego Community Health Group, a key Medi-Cal Program provider in San Diego. This augmentation figure was provided to staff by the Department of Managed Health Care (DMHC) and was based on their analysis of the need to maintain fiscal solvency. The DMHC, as well as San Diego CHG, discussed this with the DHS as well as the CA Medical Assistance Commission. No analytical issues were raised at the time to dispute the augmentation figure. In fact, the DMHC and the DHS had been working with San Diego CHG for several months prior to this legislative action to restructure their health plan. The DMHC directed San Diego CHG to implement a corrective action plan which they have been doing. The DMHC had been closely monitoring the plan's operations and had provided some independent consultants to assist them. **Yet $2 million ($1 million General Fund) was vetoed from this adjustment.**

The rates for some plans, such as all of the Geographic Managed Care Plans (in Sacramento and San Diego), are negotiated by the CA Medical Assistance Commission. This information is confidential so it is difficult to know whether these rates are or are not consistent with other Medi-Cal Managed Care Program rates.

To-date, all of the County Organized Healthcare Systems (COHS) have expressed concerns regarding the tenuous nature of their financial viability, due to the low level of capitation rates, while trying to serve the aged, blind and disabled populations along with all other Medi-Cal enrollees (COHS have mandatory enrollment of this population). **CalOPTIMA COHS received a 3 percent rate adjustment in the Budget Act of 2005**

but no other COHS obtained one, though the Legislature did also appropriate funds for the Partnership Healthcare Plan; however these funds were vetoed.

Another example is Kern Health Systems. Questions have arisen as to whether this plan is maintaining an inappropriately high level of reserves, and whether these reserves should be spent on increasing enrollment and compensation of medical providers or on the purchase of infrastructure items, such as the purchase of a building. Who is to monitor for this and how should it be monitored?

Background—5 Percent Rate Reduction. All Medi-Cal Managed Care Plans were affected by a 5 percent rate reduction effective January 1, 2004 through December 31, 2006.

Background—Quality Improvement Assessment Fee Rate Increase. Medi-Cal Managed Care Plans, except for COHS', are participating in the "Quality Improvement Assessment" fee effective as of July 1, 2005. This arrangement enables plans to pay the state a fee (6 percent) that is then matched with federal funds to provide a rate increase. The state was able to offset General Fund expenditures from this arrangement as well. This arrangement enabled plans to receive about a 3 percent increase on average. This program is scheduled to end by 2009 due to recent changes in federal law.

Background—Mercer Managed Care Rate Methodology Study. The DHS has contracted with Mercer to conduct an analyses regarding Medi-Cal Managed Care Program rates. According to the DHS, this analysis should be completed by **August 2006**. **Key objectives of this study are as follows:**

- Obtain an understanding of the rate methods used in the Medicaid programs in other states. A survey of the alternatives, including benefits provided, costs and challenges of these alternatives, is to be provided.
- Develop an independent evaluation/critique of California's current rate methodology for purposes of suggesting improvements and/or alternative methodologies. Among other things, this is to include a review of the completeness, accuracy and propriety of the database currently being utilized to determine capitation rates.
- Develop an independent review of Blue Cross paid claims to determine the potential for use as an alternative database or augmentation to a database.
- Develop an inventory and description of areas recommended for future examination to continue rate setting methodology improvements.
- Develop a Medi-Cal specific financial reporting guide, including reporting utilization statistics by major category of service and capitation risk group.

Background—Department of Health Services Financial Review of Medi-Cal Managed Care Plans. The DHS is undertaking an extensive review of the financial condition of each contractor in *all* of the Medi-Cal Managed Care Programs (i.e., Two-Plan Model, County Organized Healthcare Systems (COHS), and Geographic Managed Care (GMC)).

The DHS states that the purpose of this review and analysis is to determine short-term financial viability and solvency of health plans contracting in the Medi-Cal Program. Their primary goal will be to determine whether the state should consider funding augmentations for any plans, and if so the amount of an increase, in the May 2006 Medi-Cal Estimate.

Key data that the DHS is reviewing regarding each of the plans includes the following:

(1) *Net income.* The earnings of the company as calculated as revenues minus expenses.

(2) *Cash Flow Position.* The DHS review will analyze the liquidity of the health plan.

(3) *Tangible Net Equity.* This is a measure of the plan's financial reserves and provides a margin of financial safety if it is necessary for a plan to sustain losses over some period.

(4) *Medical Loss Ratio.* This provides the percentage of revenues devoted to providing medical care plan enrollees.

(5) *Administrative Expense Ratio.* These are costs necessarily incurred to operate a health plan.

(6) *Profit Margin.* This value shows a plan's profits or losses as a percentage and is calculated as net income divided by total revenue.

(7) *Medi-Cal Enrollment as a Percent of Total Enrollments.* This is an important factor given as it provides the ability or inability for a plan to subsidize across lines of business.

(8) Data from Most Recent Audited Financial Statements. These statements are reviewed by auditors who then consider if the health plan is a viable and ongoing entity.

Background—Loss of Confidence in Rate Calculations as Managed Care Expanded. When Managed Care plans became part of the program, the state's obligation and method of payment changed. The state now had to begin paying a fix amount per member to a health plan each month, and the health plan would agree to pay for the member's medical care. At this time, the federal CMS imposed a requirement that payments to managed care plans could not exceed, in the aggregate, what the state would have spent had the individuals remained in Fee-For-Service.

By the end of 1997, a major portion of Medi-Cal eligibles were enrolled in Managed Care plans. As such, the rate calculations for Managed Care plans had to be changed because of the loss of sufficient Fee-For-Service data. The validity of the data was compromised.

The decision was made to create a new methodology for the Two Plan Model that would place less emphasis on Fee-For-Service cost data, and gradually move to a methodology based on managed care encounter data.

Questions. The Subcommittee has requested the DHS to respond to the following questions.

1. **DHS**, Please provide a brief summary of the key outcomes from the DHS fiscal reviews. What aspects of these reviews were most useful?
2. **DHS,** Please provide an update on the activities and progress of the Mercer analysis. When will it be made available to the Legislature?
3. **DHS**, What next steps are necessary in order to craft more rational rates for the Medi-Cal Managed Care Program?

14. Medi-Cal Fee-for-Service Rates—*Discussion for Informational Purposes*

Issue. The viability of the Medi-Cal Fee-For-Service Program is critically important. For various reasons, many areas of the state will not be implementing a Medi-Cal Managed Care system, and as such, will need to have medical practitioners who are willing to be Medi-Cal providers. Low provider reimbursement rates threaten access to services for many individuals, particularly those who need specialty care services. Most aged, blind and disabled individuals primarily utilize the Fee-For-Service Program.

There are numerous reports from health researchers that clearly indicate that the rates paid to medical providers can, and often do, affect the quality of care and access to care provided to Medicaid (Medi-Cal) patients. **A lack of access to healthcare has been shown to increase the rate of avoidable hospitalizations and emergency room use, and ultimately leads to a higher state expenditure.**

As noted in many recent studies, Medi-Cal rates, particularly those paid for physician services are relatively low compared to rates paid by other major purchasers of health care. For example, physicians are paid less than $24 for a basic office visit, and the average Medi-Cal emergency physician payment per patient visit is about $65.

As noted by the LAO in their 2001-02 Analysis:

- Medi-Cal rates are low compared to Medicare and other health care purchasers;
- Medi-Cal physician rates **average about 60 percent of Medicare rates**;
- The Medi-Cal Program has not met state and federal requirements for setting rates, and ensuring reasonable access to health care;
- Medi-Cal physician rates are not based upon an assessment of relative access of Medi-Cal enrollees to quality health care or any measure of the actual costs of providing medical services; and
- The federal Medicare Program has a rational, comprehensive rate-setting system that adjusts physician rates annually.

SB 912 (Ducheny), Statutes of 2005. This enacted legislation eliminated the existing 5 percent rate reduction for Fee-For-Service providers that had gone into affect as of January 1, 2006, due to various court rulings, and would have remain in affect until December 31, 2006. This action restores rates to their existing levels.

Constituency Letters. The Subcommittee has received considerable correspondence regarding concerns with the rates paid under Medi-Cal for various services provided under the Fee-For-Service Program.

Questions. The Subcommittee has requested the DHS to respond to the following questions.

1. **DHS**, Please provide a general overview of the existing Medi-Cal Fee-For-Service rate system.

2. **DHS**, Please briefly describe the process used for the last significant rate increase for the Medi-Cal Fee-For-Service Program through the Budget Act of 2000. Was this a constructive process for allocation?

3. **DHS**, At this time, generally what would the General Fund cost of a 1 percent rate increase be? (This is often how we apply a multiply if rates are to be increased.)

15. Hearing Aid Trailer Bill Language *(See Hand Out)*

Issue. The Administration **is proposing trailer bill language to revise the Medi-Cal reimbursement for hearing aids by basing reimbursement on procedure codes developed by the DHS. The budget does not reflect any costs or savings from this proposal because the DHS states that the proposed changes reflect how the rates are presently operation.**

The DHS is seeking this change because they contend they do not have enough staff resources available to develop the mandated product-specific list and product-specific rates as presently required. They note that this is a very labor intensive project because data is not readily available. The DHS states that this statutory change will enable the DHS to update benefits and rates for hearing aids on a timely basis.

The proposed language provides the DHS with broad authority to change rates and to implement any changes through notification to providers through a Medi-Cal bulletin or the Medi-Cal provider manual.

Specifically, it would establish the maximum rate reimbursed for **hearing aids at the *lesser* of:** (1) the maximum allowable amount established by the DHS; (2) the one-unit wholesale cost, plus a markup determined by the DHS; (3) the bill amount; or (4) a rate established by the DHS' contracting program

It would establish the maximum rate reimbursed for **hearing aid supplies and accessories at the *lesser* of:** (1) the retail price; (2) the wholesale cost, plus a markup determined by the DHS; or (3) the billed amount.

It would establish the maximum rate reimbursed for **each mold or insert at the *lesser* of**: (1) the maximum amount allowable as established by the DHS; (2) the bill amount; or, (3) the rate established by the DHS' contracting program.

It would establish the maximum rate reimbursed for **repairs**, subsequent to the guarantee period, **at the *lesser* of**: (1) the invoice cost plus a markup determined by the DHS; (2) the bill amount; or (3) the rate established by the DHS' contracting program.

Background. Existing statute, enacted as trailer bill legislation through the Budget Act of 2003, requires the DHS to establish a list of hearing aids and hearing aid accessories and determine the maximum allowable product cost for each hearing aid product provided as a

benefit under Medi-Cal. It should be noted that this enabling language was proposed and adopted at the request of the DHS.

Prior to 2003, the DHS had not established a product-specific list of hearing aids and accessories, with rates for each product. Instead, the DHS used percentage mark-up rather than a product cost plus professional fee methodology that is used to determine maximum allowable product cost ("MAPC").

Subcommittee Staff Recommendation. It is recommended to adopt the proposed in order to have state statute be consistent with existing practices.

Questions. The Subcommittee has requested the DHS to respond to the following questions.

1. **DHS,** Please briefly explain the purpose of the trailer bill language and why it is desired.
2. **DHS**, Will this proposed trailer bill language result in reduced reimbursement rates?
3. **DHS**, Has the provider industry and key advocacy groups for the hearing impaired been informed about your proposed change?

16. Hospital Financing—DHS Request for Positions

Issue. The DHS is requesting **an increase of $1.680 million ($840,000 General Fund) to support 15 new positions** to conduct various activities associated with the implementation of the Hospital Waiver. In addition, the budget adjustment reflects the General Fund replacement needed to continue to support 21 existing staff that were previously funded through the interest that accrued to certain special funds. Since the Hospital Waiver replaces this funding, additional General Fund is needed to support these existing positions.

The new Hospital Waiver drastically changed the way California's safety net hospitals are reimbursed for providing inpatient hospital care to Medi-Cal enrollees and uninsured individuals. The requested 15 positions are needed to address workload associated with the development, implementation, monitoring, and reporting and on-going administration of the Waiver. This staff includes the following:

- *Medi-Cal Operations.* This staff includes (1) a Research Manager I, (2) two Research Program Specialists II, (3) two Research Analysts II, (5) an Associate Governmental Program Analyst, and (6) an Office Technician. In addition, funding for two existing positions is needed (currently unfunded).
- *Accounting.* This staff includes (1) an Accounting Officer—Specialist, and (2) an Accounting Trainee.

- *Fiscal Forecasting Branch.* This staff includes (1) a Staff Services Manager I, and (2) a Research Program Specialist II.
- *Office of Legal Services.* A Staff Counsel III is requested.

Legislative Analyst's Office Recommendation (See Hand Out). The LAO is recommending several adjustments to this proposal as noted on their hand out.

Subcommittee Staff Recommendation. It is recommended to approve the request as proposed. The Hospital Financing Waiver is highly complex and requires a considerable amount of intensive data analysis to compute the various calculations in order to operate the model and allocate funds from the various funding streams.

Questions. The Subcommittee has requested the DHS to respond to the following questions.

1. **DHS,** Please provide a brief summary of the proposal.

17. DHS Request to Convert Anti-Fraud Positions to Permanent Status

Issue. The DHS is requesting **to convert 20 three-year limited-term positions that expire as of June 30, 2006 to permanent status for an increase of $2.3 million ($824,000 General Fund).** These positions are used to conduct pre-enrollment and re-enrollment onsite reviews of applicants and current Medi-Cal providers that have been identified as high-risk for fraud or abuse.

In the Budget Act of 2003, 39 positions were approved for the Audits and Investigations section to conduct various onsite pre-enrollment reviews and re-enrollment reviews. Of these positions, 20 were deemed to be three-year limited-term because it was anticipated that the number of providers referred for these reviews would decrease over time. **However the DHS contends that this has not been the case and that the positions need to be made permanent due to workload. The DHS states that over 700 high risk provider referrals are still made to the Audits and Investigations section and that the section continues to recommend enrollment denial of about 60 percent of the providers referred.**

The DHS states that it takes an average of 130 hours to complete an onsite review of a provider. Based on this average, it would take 51 staff to keep pace with the current referrals. If the 20 positions are eliminated, the DHS contends that a backlog would be created and a reduction in denials, deactivations, placement of utilization controls and sanctions would occur.

The 20 positions the DHS wants to make include the following:

- *Medical Consultant I (3 Positions).* These positions primarily provide consultation to management and staff on various allied health aspects of medical care programs and health care delivery systems.
- *Pharmaceutical Consultant I (2 Positions).* These positions primarily provide consultation to management and staff on various pharmacological aspects of medical care programs and health care delivery systems.
- *Nurse Evaluator II (6 Positions).* These positions primarily perform onsite reviews of high-risk providers applying for enrollment and re-enrollment.
- *Health Program Auditor III (6 Positions). These positions primarily perform onsite reviews of high-risk providers applying f*or enrollment and re-enrollment.
- *Research Analyst II.* This position primarily analyzes complex data sets, and analyzes other payor sources such as Medicare to evaluate utilization patterns among payors.
- *Office Technician Typing (2 Positions).* This position primarily performs support functions to the staff above.

Background—Anti-Fraud and Provider Enrollment. In 1999 the DHS proceeded to tighten Medi-Cal provider enrollment by (1) requiring the completion of a more comprehensive application, (2) conducting an extensive background check on providers, and (3) conducting onsite reviews of high risk providers by DHS audit and medical staff. In addition, the DHS began a re-enrollment process to identify fraudulent providers and deny continued enrollment in the program.

The Budget Act of 2003 established 161.5 new positions for anti-fraud activities, of which 83 positions were devoted to increasing provider pre-enrollment and re-enrollment activities. Of these 83 positions, 39 positions were for the Audits and Investigations section to increase onsite enrollment and re-enrollment reviews. **Of these 39 positions, 20 positions were deemed to be three-year limited-term positions.**

Legislative Analyst's Office Recommendation. The LAO recommends to withhold approval of these positions pending the receipt of the 2005 Medi-Cal Error Rate Study that is intended to assess the level and nature of Medi-Cal fraud.

Subcommittee Staff Recommendation. It is recommended to approve the positions as requested.

Questions. The Subcommittee has requested the DHS to respond to the following questions.

1. **DHS**, Please provide a brief summary of the request.
2. **DHS**, When will the 2005 Medi-Cal Error Rate Study be provided to the Legislature as required?

C. ITEMS FOR VOTE ONLY-- Department of Mental Services

1. Forensic Conditional Release Program

Issue. The DMH is requesting **an increase of $11,000 (General Fund)** for the Forensic Conditional Release Program to reflect an increase in the number of Sexually Violent Predators (SVPs) that are expected to be in the Conditional Release Program (CONREP) in 2006-07. **According to the DMH, a total of $1.662 million will be expended for 12 clients that reflects an increase of $11,000 over the current year.**

Liberty Healthcare Corporation is the contractor that the DMH uses for the SVP-CONREP. The contract includes expenditures for costs associated with treatment, daily living, medical, assessment, case management, GPS tracking, vocational education, security and administrative functions.

Background—Forensic Conditional Release Program. This program provides for (1) outpatient services to patients into the Conditional Release Program (CONREP) via either a court order or as a condition of parole, and (2) hospital liaison visits to patients continuing their inpatient treatment at State Hospitals who may eventually enter CONREP. The patient population includes: (1) Not Guilty by Reason of Insanity, (2) Mentally Disordered Offenders, (3) Mentally Disordered Sex Offenders, and (4) Sexually Violent Predators. The DMH contracts with counties and private organizations to provide these mandated services in the state, although patients remain DMH's responsibility per statute when they are court-ordered into CONREP community treatment and supervision.

The program as developed by the DMH includes sex offender treatment, dynamic risk assessments, and certain screening and diagnostic tools. Supervision and monitoring tools include Global Positioning System (GPS), polygraphs, substance abuse screening, and collaboration with law enforcement.

Background—Designation of SVP: In 1995, the Legislature established a civil commitment process for offenders deemed by a court or jury to be a Sexually Violent Predator (SVP). The SPV law is designed to ensure that specified offenders receive intensive inpatient treatment, as well as outpatient treatment and supervision upon their release from state prison.

To qualify as an SVP, an offender must have committed specified sexual acts (e.g., rape, sodomy and lewd or lascivious acts with a child) involving two or more victims and have a diagnosed mental disorder that makes the individual likely to engage in sexually violent predatory behavior in the future.

Subcommittee Staff Recommendation. No issues have been raised regarding the Administration's proposal. It is **recommended for approval.**

2. Sexually Violent Predators (SVPs) Evaluation and Court Testimony

Issue. The DMH is requesting **an increase of $906,000 (General Fund) to reflect an increase in the number of SVP evaluations to be performed by private contractors, as well as costs for evaluator court testimony.**

The DMH is continuing to use a one-year regression analysis of the most recent billing data in developing the costs for SVP evaluations and court testimony. They believe this method serves as the most accurate predictor of costs at this time.

The table below summarizes the proposed budget and component parts.

SVP Program Evaluation & Court Estimate	2005-06	2006-07	**Difference**
Initial Evaluations	$1,600,000	$1,798,000	198,000
Initial Court Testimony	516,000	348,000	-168,000
Evaluation Updates	487,000	323,000	-164,000
Recommitment Evaluations	538,000	705,000	167,000
Recommitment Court Testimony	243,000	1,051,000	808,000
Recommitment Updates	400,000	461,000	61,000
Airfare Costs	138,000	141,000	3,000
Consultation Costs	46,000	47,000	1,000
Totals	**$3,968,000**	**$4,874,000**	**$906,000**

The DMH notes that report updates for recommitment evaluations are routinely required. In fact, updates are an increasing cost factor in the recommitment evaluation process, as the number of committed SVPs increase. A total of 281 recommitment updates are projected for 2005-06. For 2006-07, the regression analysis predicts that 324 recommitment updates may be needed.

Background---Overview of the Process: All SVPs first serve their sentence in a CDC prison. Through an initial records review process, the CDC and Board of Prison Terms refer records of inmates suspected of meeting SVP criteria. The DMH orders evaluations to determine whether the offender potentially qualifies for a SVP commitment.

Any inmate meeting SVP criteria then receives a clinical evaluation to determine if a diagnosed mental disorder exists. Inmates meeting all the statutory SVP criteria are referred to District Attorneys for their action. For those cases which a DA decides to file a petition, a probable cause hearing is held before a judge to determine if the facts of the case warrant a full commitment trial.

If a jury or judge finds that it is likely an individual would re-offend, then the individual is committed to the DMH State Hospital system for treatment and supervision. The statutory length of commitment is presently two years. The DMH states that almost all SVPs are recommitted every two years.

Subcommittee Staff Recommendation. It is **recommended to approve the request.** No issues have been raised.

3. Reappropriation for Certain Capital Outlay Projects

Issue. The Subcommittee is in receipt of a Finance Letter that requests reappropriation authority for several capital outlay projects. These projects are as follows:

- *Metropolitan State Hospital—Remodel Satellite Serving Kitchens (Construction).* This request would reappropriate $5.3 million General Fund for the construction phase of this project approved for funding in the Budget Act of 2005. The DMH says that reappropriation authority is needed because of delays in completing the construction design documents as a result of ongoing efforts to keep the project within the budget.

- *Metropolitan State Hospital—Construct New Main Kitchen (Construction).* This request would reappropriate $17.1 million (lease revenue bonds) for the construction phase of this project approved for funding in the Budget Act of 2005. The DMH says that reappropriation authority is needed because of delays in completing the construction design documents as a result of ongoing efforts to keep the project within the budget.

- Patton State Hospital—Renovate Admission Suite and Fire and Life Safety and Environmental Improvements, Phases II and III, EB Building (Construction). This request would reappropriate $29 million (lease revenue bonds) for the construction phase of this project approved for funding in the Budget Act of 2005. This reappropriation is necessary because working drawings need to be modified to incorporate a new HVAC system and plumbing. These tasks were deemed essential to the project once the extent of the seismic retrofit was known.

Subcommittee Staff Recommendation. It is **recommended to approve the request.** No issues have been raised.

4. Reappropriation of Medicare Part D Funds

Issue. The Subcommittee is in receipt of **a Finance Letter request to reappropriate $330,000 (General Fund) from the Budget Act of 2005 that was provided to implement the federal Medicare Part D Drug Program for the State Hospitals.** Specifically, the DMH needs to modify its billing systems to allow the state to claim federal reimbursement under the Part D Drug Program from the Prescription Drug Plans (PDPs).

The DMH wants to use these reappropriated funds to pay for contract work to make changes to the State Hospitals billing system to capture federal funds and accommodate for changes due to the Part D Drug Program.

Additional Background—DMH and DDS Responsibilities. The DDS is responsible for all client billings for both the DDS and the DMH. DMH operates systems that must interface with DDS' systems and provide the information that DDS needs to bill third parties for client care.

Subcommittee Staff Recommendation. It is **recommended to approve as proposed.**

Questions. The Subcommittee is requesting the DMH to respond to the following questions.

1. **DMH,** Please explain the need for the reappropriation authority and clarify how the DMH is going to interface with the efforts described earlier in this agenda regarding the Department of Developmental Services (DDS).

D. ITEMS FOR DISCUSSION-- Department of Mental Services

1. Revised Implementation Plan for CRIPA

Issue. The Subcommittee is in receipt of a **Finance Letter that *reduces* the Administration's January budget request by $19.6 million ($16.9 million General Fund and $2.7 million in County Realignment Funds), for total expenditures of $23.9 million ($20.7 million General Fund),** to proceed with changes within the State Hospital system to comply with requirements as directed by the U.S. Department of Justice (U.S. DOJ) and the Civil Rights of Institutionalized Persons Act (CRIPA).

The Finance Letter action retains the same number of positions as requested in January—a total of 454.7 positions—but it would phase in the positions during the fiscal year, as summarized in the table below. In its March 6th hearing, the Subcommittee had requested the DMH to revise its proposal to reflect a more realistic approach of phasing in the hiring of the positions. The DMH reviewed individual classifications and past hiring experiences in the State Hospitals and developed a phase-in plan. The DMH states that the remaining funding for positions represents slightly more than half-year funding for all of the positions.

Table—Summary of DMH Positions for State Hospitals for CRIPA

Classification of Positions	Governor's January Budget (Positions)	Finance Letter Revision (Phase In of Positions)
Senior Psychiatrist	46.7	19.2
Senior Psychologist	176.4	68
Consulting Psychologist		0.7
Psychiatric Social Worker	11.3	7.6
Rehabilitation Therapist	30.4	20.2
Registered Nurse	48.3	33.2
Psychiatric Technician	56	38.8
Health Record Technician	1	17.5
Clinical Dietitian	5.5	4.1
Special Investigator	8.6	6.1
Office Technician	21.5	36.7
Associate Mental Health Specialist	1	0.8
TOTAL	454.7 positions	252.8 positions (partial year)

The DMH states that the requested positions are in *addition* to the existing ratios for the various types of patients and beds.

Update on the Status of CRIPA Consent Decree and Enhancement Plan. The DMH and the U.S. DOJ have formally signed the agreements and have provided copies of this agreement to the Legislature **as of May 2nd. The DMH states that their Finance Letter is consistent with this agreement.**

Background—Deficiencies at State Hospitals and Need for Signed Agreement. In July 2002, the U.S. DOJ completed an on-site review of conditions at Metropolitan State Hospital. Recommendations for improvements at Metropolitan in the areas of patient assessment, treatment, and medication were then provided to the DMH. Since this time, the U.S. DOJ has identified similar conditions at Napa, Patton, and Atascadero.

A Remediation Plan to resolve CRIPA at all four State Hospitals (Coalinga was not involved), as well as a consent decree has just been formally agreed to as of May 2nd.

These documents provide a timeline for State Hospitals to address the CRIPA deficiencies and include agreements related to treatment planning, patient assessments, patient discharge planning, patient discipline, and documentation requirements. It also addresses issues regarding quality improvement, incident management and safety hazards in the facilities.

A key component to successfully addressing the CRIPA deficiencies is implementation of the "Recovery Model" at the State Hospitals. Under this model, the hospital's role is to assist individuals in reaching their goals through individualized mental health treatment, and self determination. This model includes such elements as the following:

- Treatment is delivered to meet individual's needs for recovery in a variety of settings including the living units, psychosocial rehabilitation malls and the broader hospital community.
- There are a broad array of interventions available to all individuals rather than a limited array.
- A number of new tracking and monitoring systems must be put in place to continually assess all major clinical and administrative functions in the hospitals.
- Incentive programs—called "By Choice" will be used to motivate individuals to make positive changes in their lives.

Legislative Analyst's Office Recommendation--Pending. As of the release of this documents, the LAO was analyzing the newly provided information. As such, their recommendation is pending.

Subcommittee Staff Recommendation. It is **recommended to approve** the modified plan as proposed since it meets the requirements of the CRIPA degree.

Questions. The Subcommittee has requested the DMH to respond to the following questions.

1. **DMH**, Please briefly describe the Finance Letter changes.

2. Implementation of the Wellness and Recovery Model Support System--CRIPA

Issue. The Subcommittee **is in receipt of a Finance Letter requesting a total increase of $2.5 million ($2.4 million General Fund and $100,000 County Realignment Funds) to support the implementation of the Wellness and Recovery Model Support System (WaRMSS).** WaRMSS is the information technology support system the DMH needs to meet the U.S. DOJ consent decree pursuant to CRIPA.

It should also be noted that the DMH is redirecting funds to purchase 978 new computers at the State Hospitals that will place computers in every treatment area and provide access for treatment providers.

The DMH states that a Feasibility Study Report (FSR) in support of WaRMSS has been approved by the DOF. This is a web-based application for use by all of the State Hospitals. It is intended to (1) automate the treatment and activity scheduling of all patients using the Wellness and Recovery Plan process (including assessment tools and forms), and (2) integrate with the Hospital Clinical Operations and each individual's State Hospitals' Human Resources system. **There are several phases and modules for the WaRMSS application (all outlined in the FSR). The DMH states that all of the components of WaRMSS are contained in the proposed CRIPA remediation plan.**

Of the total amount, $1.8 million (General Fund) is in the Headquarters' state support item to (1) support 5 new permanent positions, and (2) provide $958,000 in contract funds for software development and project oversight. The remaining amount of $706,000 is in the State Hospital item to fund 10 new permanent positions at the State Hospitals to support the system.

The five positions for Headquarters' support include the following:

- *Project Manager (Senior Programmer Analyst).* Key functions of this position include: (1) managing the overall project plan, including issue tracking, risk management, change control and project budget; and (2) facilitating change management after implementation, including managing quality assurance for application fixes and confirming enhancements prior to release into production.
- *Data Base Administrator (Senior Programmer Analyst).* Key functions of this position include: (1) evaluating technical deliverables, (2) perform code reviews, (3) oversee all aspects of data and its management and security, and (4) facilitate all technical development, testing and production endeavors.
- *Enterprise Data Base Manager (Senior Programmer Analyst).* Key functions of this position include: (1) managing a major upgrade of the current Hospital Clinical Operations Data Store (i.e., the primary patient data interface for WaRMSS) which includes real-time updates from the mainframe that will propagate to the WaRMSS system; and (2) maintaining and enhancing the interface processes and procedures for data repositories.
- *Staff Programmer Analyst's (Two Positions).* These positions will provide workflow and technical expertise alongside the contractors and will primarily act as developers,

helping in low-level design, construction and implementation of the systems necessary for WaRMSS production. They will test and document all systems and sub-systems and will be the primary resources for the correction of found irregularities. These positions will also conduct training, maintain documentation, and perform help desk functions after project implementation.

The $958,000 in contract funds will be used to: (1) provide independent project oversight ($95,000); (2) provide independent verification and validation of the project ($95,000); and (3) $768,000 for software customization.

The remaining amount of $706,000 is in the State Hospital item to fund 10 new Associate Information Systems Analyst positions at the State Hospitals to support the system. These positions will be used to support the desktop computers (978 computers purchased in the current-year through redirected funding). The DMH states that these positions are based on the normal 1 support person to every 100 workstations concept that has been used previously. **Of the 10 positions, three will be half-year positions to reflect that 266 workstations will be used by clinical staff that will be hired in January 2007 and the workstations will not need support until then.**

Subcommittee Staff Recommendation. It is recommended to approve as proposed.

Questions. The Subcommittee has requested the DMH to respond to the following questions.

1. **DMH**, Please provide a brief summary of the Finance Letter.
2. **DMH**, How does WaRMSS specifically address the issues raised by the U.S. DOJ regarding CRIPA?

3. Redirection of Funding to Support State and Federal Lawsuits

Issue. The Subcommittee is in receipt of a Finance **Letter requesting to redirect $513,000 (General Fund) from savings obtained from workers' compensation reductions within the State Hospital appropriation to support 5 staff to manage work related to lawsuits.** The requested staff include: (1) a Staff Services Manager III, (2) a Consulting Psychologist, (3) a Staff Services Manager II, and (4) two Associate Governmental Program Analysts. **As discussed below, four of the positions pertain to the Coleman case and one pertains to CRIPA.**

Four of these staff are requested to (1) manage expanding inpatient treatment programs operated by the DMH for the CA Department of Corrections and Rehabilitation (CDCR), **(2)** coordinate the increasing patient referral process between CDCR and DMH, and **(3)** manage and respond to increasing compliance requirements addressed in the Special Master's Report (15th monitoring report) in the Coleman v. Schwarzenegger (Coleman) case. This report resulted in a court order on March 2, 2006.

The DMH notes that they have never been allocated Headquarters' staff to address added workload related to the CDCR functions. In the last several years the DMH has activated new programs for CDCR at the Salinas Valley Psychiatric Program, Coalinga State Hospital, Atascadero State Hospital and Metropolitan State Hospital. The growth in the CDCR caseload and the increase in court related requirements has been at the expense of other DMH functions and workload.

Court related requirements and subsequent CDCR workload handled by the DMH include the : (1) provision of oversight and monitoring of the admission, discharge and referral process; (2) operation of the inpatient treatment programs both within the State Hospitals and the two psychiatric programs; (3) completion of clinical reviews to ensure compliance with the requirements outlined by the Special Master regarding clinical programs, movement, program guides, operating policies and procedures; (4) training of clinicians on new processes and procedures; and (5) provision of specific data upon request. **The four positions—Staff Services Manager II, Consulting Psychologist, and the two Associate Governmental Program Analysts—would be used to address these needs.**

The Staff Services Manager III position would be used as a "Business Manager" to oversee the implementation of the U.S. DOJ CRIPA approved enhancement plan in all of the State Hospitals. This position would document all administrative aspects of the enhancement plan through a business plan, which describes how the hospitals will implement the enhancement plan. The DMH notes that the changes being undertaken at the State Hospitals are fundamental, reaching to every staff member, and will require significant training, reorientation and supports if change is expected to take hold and be maintained over time.

Among other things, specific tasks for the Business Manager include the following:

- Organize and facilitate advisory meetings with consultants, advisory groups and treatment enhancement coordinators to develop, implement and amend the business and change management plans as necessary;
- Conduct site visits to State Hospitals to review planning and implementation of CRIPA enhancement plans;
- Participate in State Hospital staff trainings and in specific workgroups at the facilities;
- Monitor program compliance through review of reports, and corrective action plans;
- Prepare business rules and requirements for the WaRMSS project manager; and
- Update business and change management plans as needed;

Subcommittee Staff Recommendation. It is recommended to approve as proposed.

Questions. The Subcommittee has requested the DMH to respond to the following question.

1. **DMH**, Please briefly describe the Finance Letter request.

4. Augmentation for Continued Implementation of Mental Health Services Act

Issue. The Subcommittee is in **receipt of a Finance Letter requesting an increase of $10.6 million (Mental Health Services Act Funds) for contracts and to support 11 new positions.** The changes to the proposed contracts are shown in the Hand Out.

The 11 requested positions include the following:

- Staff Mental Health Specialists (three)—for the systems of care section;
- Associate Governmental Program Analyst—for the budget office;
- Staff Services Manager I—for the contract office;
- Accountant I—for the accounting office;
- Office Technician—for the accounting office;
- Business Services Assistant—for the business services office;
- Mental Health Specialists (two)—for local assistance financial support and related functions; and
- Office Technician—for the office of multicultural services.

The DMH states that these various positions are needed in order to conduct various functions as required by the Act.

Background—Mental Health Services Act. The DMH has recently provided the Legislature with a report on implementation activities as required (received February 2006). **This report was discussed in the March 6th Subcommittee hearing. Another**

update regarding implementation activities is to be provided in May as required by trailer bill legislation enacted in the Budget Act of 2005.

Most of the Act's funding will be provided to County Mental Health programs to fund programs consistent with their approved local plans. The Act provides for a *continuous appropriation* of the funds to a special fund designated for this purpose.

The Mental Health Services Oversight and Accountability Commission (OAC) is established to implement the Act and has the role of reviewing and approving certain county expenditures authorized by the measure. The OAC has been meeting regularly to discuss issues and an Executive Director to the Commission was recently hired.

Additional Background—Summary of Key Aspects of Mental Health Services Act (Proposition 63, 2004). The Mental Health Services Act addresses a broad spectrum of prevention, early intervention and service needs and the necessary infrastructure, technology and training elements that will effectively support the local mental health system.

The Act imposes a 1 percent income tax on personal income in excess of $1 million. The Act is projected to generate about $254 million in 2004-05, $683 million in 2005-06 and $690 million in 2006-07 and increasing amounts thereafter.

The six components and the required funding percentage specified in the Act for 2004-05 through 2007-08 are shown in the table below.

Table: Percent Funding by Component as required by Act

Six Component of MHSA Act	2004-05	2005-06	2006-07	2007-08
Local Planning	5%	5%	5%	5%
Community Services & Supports	0	55%	55%	55%
Education & Training	45%	10%	10%	10%
Capital Facilities & Technology	45%	10%	10%	10%
State Implementation/Admin	5%	5%	5%	5%
Prevention	0	20%	20%	20%
TOTALS	100 %		100 %	100 %

- Local Planning (County plans): Each county must engage in a local process involving clients, families, caregivers, and partner agencies to identify community issues related to mental illness and resulting from lack of community services and supports. **Each county is to submit for state review and approval a three-year plan for the delivery of mental health services within their jurisdiction.** Counties are also required to provide annual updates and expenditure plans for the provision of mental health services.
- Community Services and Supports. These are the programs, services, and strategies that are being identified by each county through its stakeholder process to serve

unserved and underserved populations, with an emphasis on eliminating racial disparity.

- Education & Training. This component will be used for workforce development programs to remedy the shortage of qualified individuals to provide services to address severe mental illness.
- Capital Facilities and Technology. This component is intended to support implementation of the Community Services and Supports programs at the local level. Funds can be used for capital outlay and to improve or replace existing information technology systems and related infrastructure needs.
- Prevention & Early Intervention. These funds are to be used to support the design of programs to prevent mental illness from becoming severe and disabling.

Legislative Analyst's Office Recommendation—See Hand Out. The LAO is recommends reducing reduce the Finance Letter request **by a total of $1.7 million** (Mental Health Services Act Funds) by **(1)** reducing $1.350 million from the contract services, and **(2)** reducing $372,000 and deleting 5 positions from the state support request.

Subcommittee Staff Recommendation. It is recommended **to approve the Finance Letter as proposed.** The need for resources is evident based upon the requirements contained within the Proposition. Further the Mental Health Services Oversight and Accountability Commission (OAC) has been reviewing and discussing these needs in public forums for the past few months. Many of the contract adjustments pertain to ensuring public access and constituency participation of consumers and family members.

Questions. The Subcommittee has requested the DMH to respond to the following questions.

1. **DMH**, Please provide a brief summary of the Finance Letter request.

2. **DMH,** Please explain why changes to the contracts are necessary.

D. ITEMS FOR DISCUSSION—Managed Risk Medical Insurance Board

1. MRMIB Request for Staff for Mental Health Services Oversight-- HFP

Issue. The MRMIB **requests an increase of $432,000** ($151,000 Mental Health Services Fund from Proposition 63 and $281,000 in federal funds) to **(1)** hire two new positions, and **(2)** provide $266,000 in one-time only contract funds to UC San Francisco (UCSF) to do an evaluation of the HFP Program's Mental Health Delivery System and to craft a strategy for monitoring outcomes.

According to the MRMIB, this proposal would provide staff support and funding for an existing project which was initiated using some grant funds obtained from the CA Endowment. Phase I of this evaluation is to be provided to the MRMIB by UCSF in May 2006.

The requested $266,000 in contract funds would be used to conduct Phases II and III of this UCSF evaluation. This evaluation would focus on delivery systems and coordination efforts used to provide mental health and substance abuse treatment services to children enrolled in the HFP, and a strategy for monitoring program outcomes.

The MRMIB states that the key objectives of this proposed evaluation are as follows:

- Assess the extent to which children diagnosed as needing treatment for serious emotional disturbance (SED) are receiving adequate services within the HFP, including the linkage to County Mental Health;
- Assess the effectiveness of the coordination of these children's care between the County Mental Health system and HFP participating health plans;
- Identify other service delivery options for the MRMIB's consideration that would assure accountability, continuity of care, and access to services under the HFP Program for this population; and
- Provide a set of recommendations to improve the HFP Program's delivery system and ensure quality of care.

The MRMIB would hire two positions—a Research Program Specialist I and a Staff Services Analyst--to do the following key activities:

- Provide consultation and information to families to assure they have a thorough understanding of the HFP Mental Health Delivery System;
- Assist families in resolving conflicts they may have with either the HFP health plan or County Mental Health regarding access to mental health services under the HFP;
- Serve as a liaison between the health programs in addressing a variety of issues related to access and coordination of services;
- Provide staff support to the UCSF evaluation;
- Participate in the Department of Mental Health's Proposition 63 workgroup;

- Develop a survey instrument to assess the level of satisfaction of families before and after the implementation of remedies/recommendations resulting from the UCSF evaluation; and
- Oversee the completion of a customer satisfaction survey (before and after) evaluating the impact of new strategies as they are implemented;

Additional Background—The Healthy Families Mental Health Delivery System. Under the HFP, participating health plans are responsible for providing basic mental health services, including inpatient and outpatient services for *most* mental health conditions. **Health plans also provide the first 30-days of inpatient care for children who are diagnosed with serve emotional disturbances (SED). County Mental Health Plans cover all outpatient services and inpatient services *beyond* the first 30-days for SED treatment.**

The delivery of mental health services was established in this manner through the enabling HFP state statute because County Mental Health Plans provided a significant portion of SED treatment in California and had the experience necessary to treat this condition. After the implementation of the HFP, the California Mental Health Parity Law required health plans licensed under the Know Keene Act to provide treatment for serious mental illnesses, including SED treatment for children.

Since a significant amount of effort was invested in establishing a referral and reimbursement system for SED treatment by County Mental Health Plans, the MRMIB directed health plans participating in the HFP to obtain an exemption from the section of the Mental Health Parity Law that requires plans to provide SED treatment. As such health plans participating in the HFP obtain an exemption from the Department of Managed Health Care and are referring potential SED children to County Mental Health Plans for assessment and treatment.

To facilitate the care of SED children enrolled in the HFP, the MRMIB directs health plans to enter into Memorandum of Understandings (MOUs) with County Mental Health whenever feasible. These MOUs define the responsibilities of each party for the coordination of services for children enrolled in the HFP who are diagnosed with SED. Generally, County Mental Health Plans treat HFP enrollees to the extent their resources will allow.

Subcommittee Staff Recommendation. It is recommended **to approve the $266,000 ($93,000 Mental Health Services Fund, Proposition 63) to continue the UCSF evaluation of the HFP Mental Health Delivery System but to *deny* the request for two positions.** In addition, it is recommended to **adopt uncodified trailer bill language**, as shown below, so that the Legislature and public can be assured of receiving the outcomes from the UCSF evaluation.

Continuation of the evaluation would be constructive since an evaluation of the HFP Mental Health Delivery System has not been conducted. Various changes to the mental health system (both public and private) have occurred since enactment of the enabling HFP statute and new strategies may be warranted.

It is recommended to deny the two positions for several reasons. *First*, the use of Proposition 63 funds (Mental Health Services Fund) to support these positions would not be appropriate. Most of the key functions of these positions pertain to supporting the *existing* program structure. As such the use of Proposition 63 funds here could be viewed as a "supplanting" versus a "supplementing" situation. Proposition 63 clearly articulates that funds must be used to further the provision of mental health services and must not be used to fund or replace existing requirements. The operation and oversight of the HFP Mental Health Delivery

System benefit is an ongoing function that was established in the enabling legislation and program. Existing positions should be used to ensure the quality and efficacy of this delivery system.

Second, some of the other key functions the positions are to accomplish pertain to oversight of the evaluation contractor. The contractor was hired using foundation grant funds and is in the process of completing Phase I of the evaluation. As such, the MRMIB has already been providing contractor oversight and chose to do this on their own volition. Existing resources should therefore be available for this activity.

Third, the other key functions of these positions pertain to participating in meetings with the DMH on Proposition 63 issues. This can be done with existing resources.

The recommended uncodified trailer bill language is as follows:

> "The Managed Risk Medical Insurance Board shall provide the fiscal and policy chairs of the Legislature with copies of each of the individual phases of the evaluation being conducted regarding the Healthy Families Program and the provision of mental health and substance abuse treatment services. These copies shall be provided on a flow basis as appropriate when completed by the contractor.

Questions. The Subcommittee has requested the MRMIB to respond to the following questions.

1. MRMIB, Please briefly describe the request.
2. MRMIB, How is the mental health benefit and coordination being monitored now?
3. MRMIB, When will the Phase I evaluation be provided to the Legislature?

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